

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13879

13816

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) Sabillasville | | c. LENGTH OF STAY IN 1b Lifetime | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sabillasville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home | | | | d. STREET ADDRESS 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Alvin Middle Arthur Last Anderson | | | | 4. DATE OF DEATH Month Dec. Day 26 Year 1960 | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. ? 1893 | |
| 9. AGE (In years last birthday) 67 yrs. | | IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. | | IF UNDER 24 HRS. Months 67 Days 67 Hours 67 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Farmers | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Albert Anderson | | | | 14. MOTHER'S MAIDEN NAME Nettie Pryor | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 216-14-6618 | | 17. INFORMANT Francis Manahan | | Address Sabillasville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.6 IMMEDIATE CAUSE (a) Heart disease arteriosclerotic type - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1959 to Dec 26, 1960 , that (I) (we) last saw the deceased alive on Dec. 10 1960 , and that death occurred at 4:30 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE James K. Gray | | | | 22b. DATE SIGNED Dec 26 1960 | | 22c. PHYSICIAN'S NAME (Type) James K. Gray | |
| 22d. ADDRESS Thurmont, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-29-60 | | 23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery | | 23d. LOCATION (City, town, or county) (State) Thurmont, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Crager | | | | ADDRESS Thurmont, Md. | | 25a. REC'D BY REGISTRAR DATE DEC 30 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Wm. S. Kraus | | | |

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13817

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|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b Lifetime | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | | | e. STREET ADDRESS 346 East Third Street | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Annie VanFossen Atkinson | | | | 4. DATE OF DEATH Month Day Year December 1, 19 60 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 11, 1881 | |
| 9. AGE (In years last birthday) 79 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 11. BIRTHPLACE (State or foreign country) Frederick, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME W. Scott VanFossen | | | | 14. MOTHER'S MAIDEN NAME Harriet L. Dutrow | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mrs. Paul S. Micheal 216 Lindbergh Ave. Fred. Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF COLON 153-8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/1 19 60 to 11/30 19 60 , that (I) (we) last saw the deceased alive on 11/30 19 60 , and that death occurred at 12 M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Richard C. Reynolds | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12/1/60 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Richard C. Reynolds | | | | 22d. ADDRESS 9 East Church Street Frederick, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 3, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey Jr. | | | | ADDRESS Frederick, Maryland | | 25a. REC'D BY REGISTRAR DATE DEC 5 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles L. Knaus | | | |

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2014

1204

§ 1. *Enacted*

304 J. L. Loeferle

Received 20 October 2004

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13818

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| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | | | c. LENGTH OF STAY IN 1b <u>2 hrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 4. DATE OF DECEASED (Type or print) First <u>Baer</u> Middle <u>Baby</u> Last <u>Girl</u> <u>BAER</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>1960</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-24-60</u> | |
| 9. AGE (In years last birthday) yrs. <u>2</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Richard Donald Baer</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Emma Irene Ditterman</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Father - 223 East Third St</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity (cause unknown)</u> (c) <u>—</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 24, 1960</u> to <u>Dec. 24, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec. 24, 1960</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Bernard O. Thomas Jr.</u> M.D. | | | | 22b. DATE <u>12/24/1960</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Bernard O. Thomas, Jr., M.D.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Dec. 27, 1960</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u> | | | | 25a. REC'D BY REGISTRAR <u>442800</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hance</u> | |

2069181XV2

CHARTER OF 1845

1845

The Charter of 1845 is a document that outlines the principles and objectives of the organization. It was adopted by the General Assembly on the 15th day of May, 1845. The Charter is divided into several sections, each dealing with a different aspect of the organization's structure and function. The first section deals with the purpose and objects of the organization, while the second section deals with the powers and duties of the General Assembly. The third section deals with the powers and duties of the Executive Committee, and the fourth section deals with the powers and duties of the various departments of the organization. The Charter is a fundamental document for the organization, and it is essential that it be carefully studied and understood by all members.

The Charter of 1845 is a document that outlines the principles and objectives of the organization. It was adopted by the General Assembly on the 15th day of May, 1845. The Charter is divided into several sections, each dealing with a different aspect of the organization's structure and function. The first section deals with the purpose and objects of the organization, while the second section deals with the powers and duties of the General Assembly. The third section deals with the powers and duties of the Executive Committee, and the fourth section deals with the powers and duties of the various departments of the organization. The Charter is a fundamental document for the organization, and it is essential that it be carefully studied and understood by all members.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13880 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13819

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor, Rural | | c. LENGTH OF STAY IN 1b Years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 2 | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor, Rural | |
| 3. NAME OF DECEASED (Type or print) Charles Theodore Bair | | 4. DATE OF DEATH Month December Day 28 , Year 19 60 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 18, 1881 |
| 9. AGE (In years last birthday) 79 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) millers, grinding | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY U. S. | |
| 13. FATHER'S NAME George E. Bair | | 14. MOTHER'S MAIDEN NAME Annie Riggle | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 212-14-6418 | |
| 17. INFORMANT Mrs. Daisy Condon, Mt. Airy, Md. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation by hanging 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Suicide DUE TO (c) | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20d. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE B. O. Thomas | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/28/60 | |
| EXAMINER'S NAME (Type) B. O. Thomas, MD. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Frederick, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/31/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery | | 22d. LOCATION (City, town, or county) (State) Winfield, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE D. D. Hartzler & Sons | | 24a. REC'D BY REGISTRAR JAN 3 '61 | |
| ADDRESS New Windsor, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kline | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and to any event within 72 hours after death.

1905

OFFICE OF THE STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH BOARD

1. Name of Deceased: _____

2. Age: _____

3. Sex: _____

4. Race: _____

5. Date of Death: _____

6. Place of Death: _____

7. Cause of Death: _____

8. Manner of Death: _____

9. Signature of Examiner: _____

10. Signature of Coroner: _____

11. Signature of Physician: _____

12. Signature of Medical Examiner: _____

13. Signature of Medical Examiner: _____

14. Signature of Medical Examiner: _____

15. Signature of Medical Examiner: _____

16. Signature of Medical Examiner: _____

17. Signature of Medical Examiner: _____

18. Signature of Medical Examiner: _____

19. Signature of Medical Examiner: _____

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99. Signature of Medical Examiner: _____

100. Signature of Medical Examiner: _____

13881

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|---------------------------------------|--|--|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY FREDERICK | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EN ROUTE | | | | c. LENGTH OF STAY IN 1b TO | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last HILDA EAVS BOHN | | | | 4. DATE OF DEATH Month Day Year DEC 12 1960 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUG 17 - 1900 | | 9. AGE (In years last birthday) 60 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME DANIEL O METZ | | | | 14. MOTHER'S MAIDEN NAME OLIVIA EAVS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | INFORMANT Address DAVID R BOHN UNION BRIDGE MD R2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 744-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) muscular Dystrophy DUE TO (c) 2 year | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 1959 to Dec 12 1960 that I last saw the deceased alive on Nov 12 1960 , and that death occurred at 6:00 P.M. from the causes and on the date stated above. ADDRESS (Street, City or town, state) Union Bridge MD 21360 DATE SIGNED DEC 16 '60 | | | | | | | |
| ACTUAL SIGNATURE J. H. MESSLER M.D. | | | | PHYSICIAN'S NAME (Type) J. H. MESSLER, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 12/15/60 | | 22c. NAME OF CEMETERY OR CREMATORY BEAVER DAM | | 22d. LOCATION (City, town, or county) (State) FREDERICK CO MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE D. Hartzler ADDRESS Union Bridge, Md | | | | 24a. REC'D BY REGISTRAR DEC 16 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13821

13871

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick c. LENGTH OF STAY IN 1b years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 East E St. | | | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick d. STREET ADDRESS 1 East E St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First Iulu Middle E. Last Brown | | | | 4. DATE OF DEATH Month 12 Day 9 Year 1960 | | | |
| 5 SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH 9/31/1885 | |
| 9 AGE (in years lost birthday) 75 yrs | | IF UNDER 1 YEAR Months 7 Days 12 Hours 9 Min. | | IF UNDER 24 HRS Hours 9 Min. | | | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME James Gordon | | | | 14 MOTHER'S MAIDEN NAME Nancy ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17 INFORMANT Mrs. Glenn Sowers, Brunswick, Md. Address 1 East E. St. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4 4 3 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Congestive Heart Failure DUE TO (c) Hypertension | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day 5 yrs. 5 yrs. | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a. m. 1 p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from Dec. 31, 1958 to Dec. 9, 1960 that (I) (we) last saw the deceased alive on Dec. 9, 1960 and that death occurred at 6:00 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a SIGNATURE C.T. Byron Kao, M.D. | | | | 22b DATE SIGNED Dec 14 1960 | | 22c PHYSICIAN'S NAME (Type) C.T. Byron Kao, M.D. | |
| 22d ADDRESS 15 S. Maryland Ave., Brunswick, Md. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE THEREOF | | 23c NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| burial | | 12/11/1960 | | Pleasant View Cem. | | Middletown, Md. | |
| 24 FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, | | | | ADDRESS Middletown, Md. | | 25a REC'D BY REGISTRAR DATE DEC 13 '60 | |
| | | | | | | 25b REGISTRAR'S SIGNATURE C. L. S. Thomas | |



CERTIFICATE OF DEATH

Reg. Dist. No.

13822

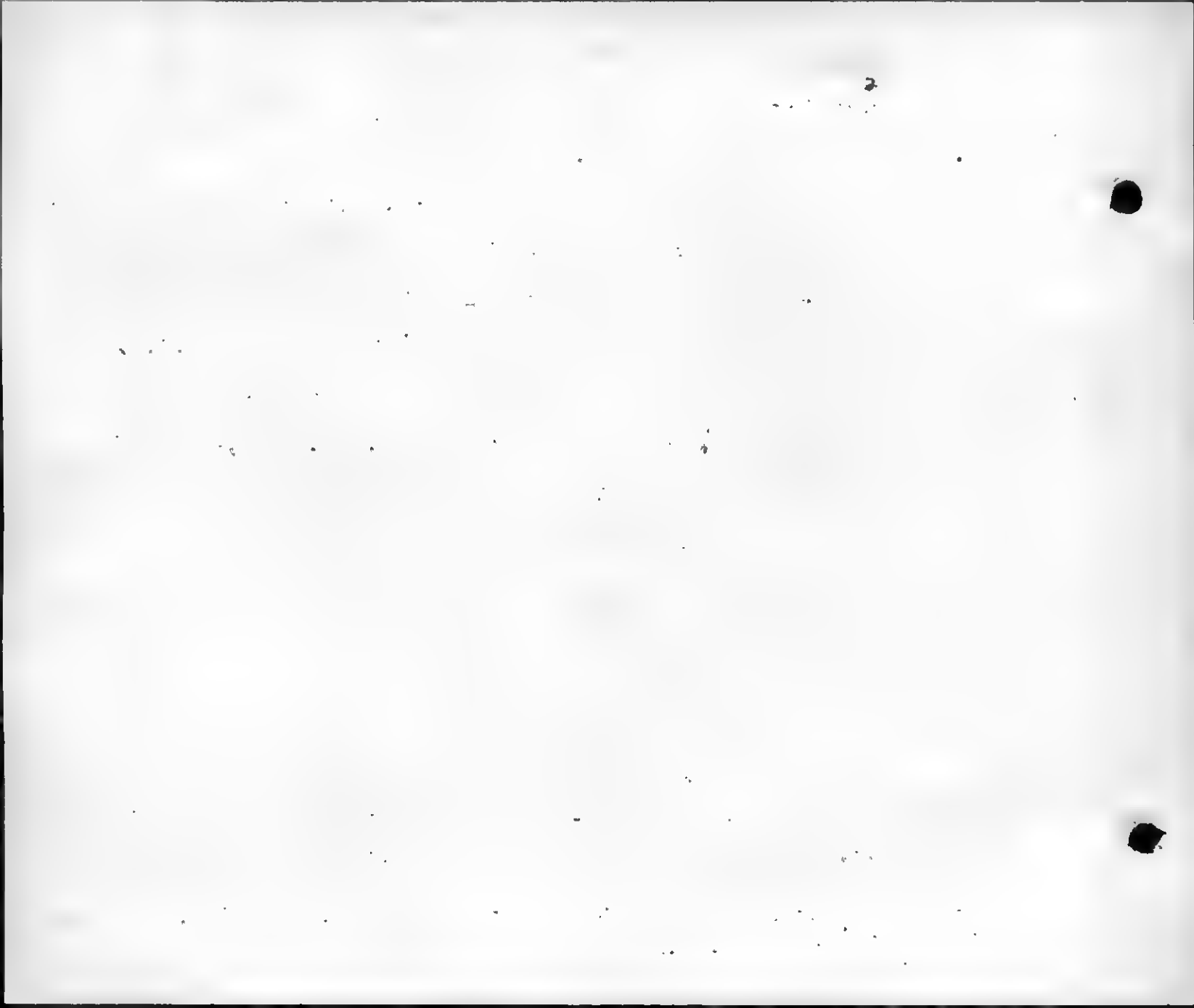
13872

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|---|---------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick | |
| c. LENGTH OF STAY IN 1b 15 years | | d. STREET ADDRESS 111 East "A" Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION West "B" Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) John First Thomas Middle Bush Last | | 4. DATE OF DEATH Month 12 Day 14 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE Col. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-15-1895 |
| 9. AGE (In years last birthday) yrs 65 | | 10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor | | 10b. KIND OF BUSINESS OR INDUSTRY Apartment House | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Un Known | | 14. MOTHER'S MAIDEN NAME Susan Bush | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 219-12-0912 | |
| 17. INFORMANT James Beamer, Brunswick, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO chronic pneumonia Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) 11/15/55 - 1-1-12 DUE TO chronic pneumonia (c) 11/15/55 - 1-1-12 DUE TO chronic pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 11/15/55 - 1-1-12 INTERVAL BETWEEN ONSET AND DEATH 11 yrs. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12-14-1960 to 12-14-1960 , that I last saw the deceased alive on 12-14-1960 , and that death occurred at 3 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Maryland DATE SIGNED 12-16-60 | | | |
| ACTUAL SIGNATURE C.E. Pruitt | | PHYSICIAN'S NAME (Type) Brunswick Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-17-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley | | 22d. LOCATION (City, town, or county) (State) Garrots Mills, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. E. Pruitt | | ADDRESS Brunswick, Maryland | |
| 24a. REC'D BY REGISTRAR DEC 23 '60 | | 24b. REGISTRAR'S SIGNATURE C. E. Pruitt | |

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13843

CERTIFICATE OF DEATH

13823

Reg. Dist. No.

| | | | |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u> | |
| c. LENGTH OF STAY IN lb <u>DOA</u> | | d. STREET ADDRESS <u>Maryland</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Eugene</u> Last <u>Cordell</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 1, 1918</u> |
| 9. AGE (In years last birthday) <u>42</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto mechanic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>State Road Dept.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME <u>Eugene Cordell</u> | | 14. MOTHER'S MAIDEN NAME <u>Nettie Beall</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.II</u> | | 16. SOCIAL SECURITY NO. <u>218-10-9738</u> | |
| INFORMANT <u>Mrs. Edward E. Cordell</u> | | Address <u>Same as 2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>443 X</u> IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC-HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (b) <u>ACUTE CARDIAC DECOMPENSATION</u> DUE TO (c) <u>CIRRHOSIS OF THE LIVER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>3 DAYS</u> <u>6 MONTHS</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>12/12</u> , 19 <u>60</u> , to <u>12/15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/14</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>James P. Kerr</u> M.D. <u>Damascus, Md.</u> DATE SIGNED <u>12/15/60</u> PHYSICIAN'S NAME (Type) <u>Dr. James P. Kerr</u> <u>Damascus, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12-17-60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Clarksburg Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DEC 19 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Island

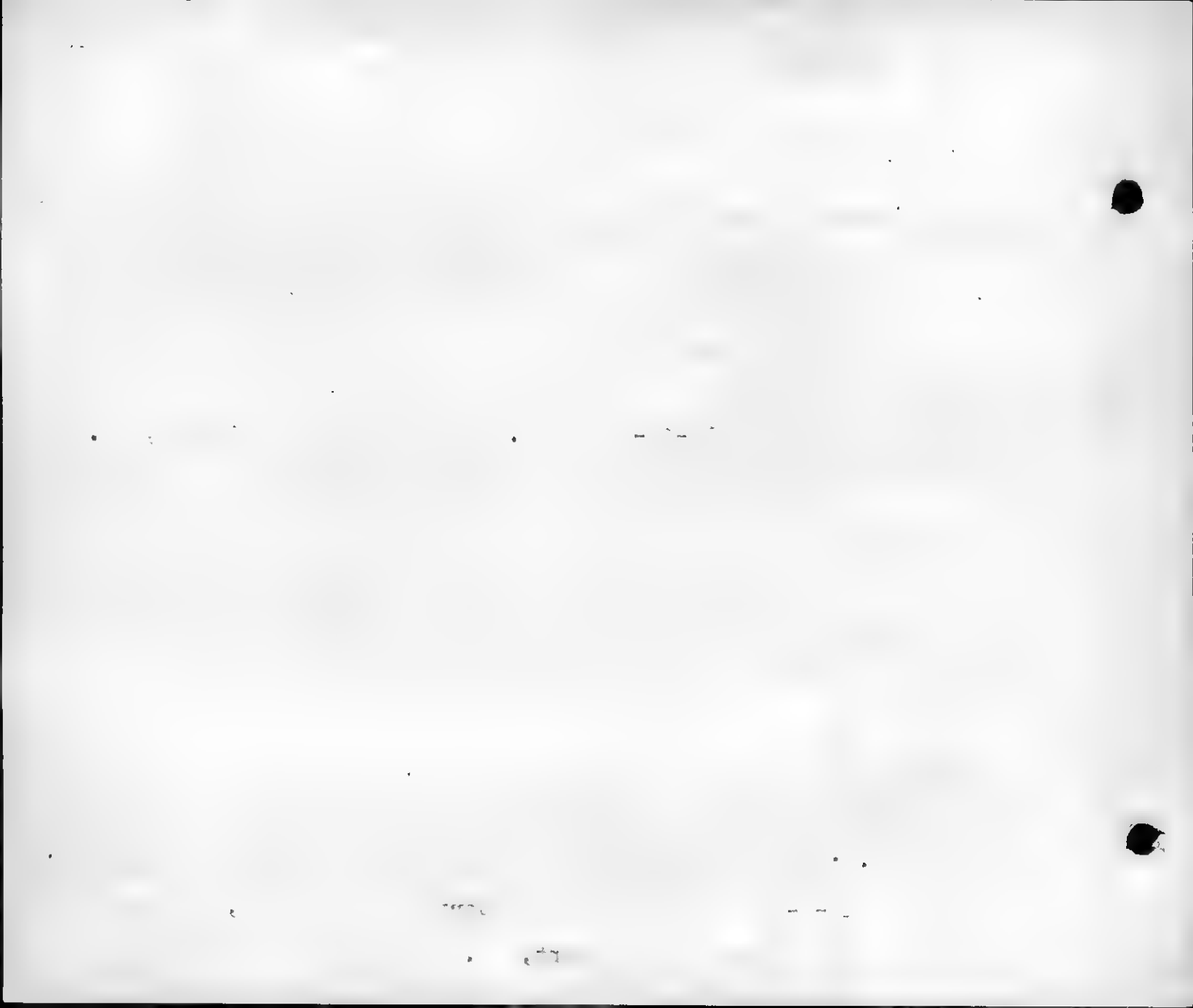
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13844

13824

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Frederick</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewistown, Maryland</u> | | | |
| c. LENGTH OF STAY IN 1b <u>2 days</u> | | | | d. STREET ADDRESS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur W. Crebbs</u> | | | | 4. DATE OF DEATH Month Day Year <u>DECEMBER 2 1960</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/9/1897</u> | | 9. AGE (In years last birthday) yrs. <u>63</u> | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>David Lee Crebbs</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Minnie Esley</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-32-4343</u> | | 17. INFORMANT <u>Mrs. Julia Crebbs</u> | | Address <u>Lewistown, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of colon with widespread metastases</u> <u>153-8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Nov. 30 - Dec. 2</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 30</u> 19 <u>60</u> , to <u>Dec. 2</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Dec. 2</u> 19 <u>60</u> , and that death occurred at <u>10:15</u> M., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>A. A. Pearre</u> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>12/2/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>A. A. Pearre</u> | | | | 22d. ADDRESS <u>4 E. Church St. Frederick Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12-6-60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Lewistown Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Lewistown, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. ...</u> | | | | ADDRESS <u>Thurmont, Md.</u> | | 25a. REC'D BY REGISTRAR DATE <u>DEC 6 '60</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u> | | | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 7, MARYLAND
CERTIFICATE OF DEATH

13825

13845

| | | | | | | | |
|---|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN lb Minutes | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital, D.O.A. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First ROBERT Middle BOUCHER Last CROTHERS | | | | 4. DATE OF DEATH Month December Day 23 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH December 21, 1893 | |
| 9. AGE (In years last birthday) yrs. 67 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired President | | 10b. KIND OF BUSINESS OR INDUSTRY Lime Company | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME William J. Crothers | | | |
| 14. MOTHER'S MAIDEN NAME Harriett Boucher | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | | |
| 16. SOCIAL SECURITY NO. 217-10-9400 | | | | 17. INFORMANT Mrs. Adelle S. Crothers, Same as Item #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 425.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 10 years | | | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month July Day 19 Year 1960 Hour a. m. p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frederick, Maryland | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1960 to Dec. 1960 , that (I) (we) last saw the deceased alive on 12/23 1960 , and that death occurred at 5:30 M., from the causes and on the date stated above. | | | | | | | 22b. DATE SIGNED 12/24/60 |
| 22a. SIGNATURE Richard C. Reynolds, | | | | 22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds, M.D. | | 22d. ADDRESS East Church Street, Frederick, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/27/1960 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 25a. REC'D BY REGISTRAR DATE DEC 28 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kline | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13846

13826

| | | | | | |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b 15 Days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | | d. STREET ADDRESS 700 East Patrick Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First IRVIN Middle FRANKLIN HILL Last CROUSE | | | 4. DATE OF DEATH Month December Day 26 , Year 60 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 5, 1905 | 9. AGE (In years low birthday) yrs 55 | IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Sheriff & Turnkey | | 10b. KIND OF BUSINESS OR INDUSTRY County Jail | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Lewis Edward Crouse | | | 14. MOTHER'S MAIDEN NAME Fannie Wilhide | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-10-2970 | | 17. INFORMANT Mrs. Elsie E. Crouse-Same as item #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 4:10 P.M. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH 15 Days 4-5 years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 27, 1956 to Dec 26, 1960 , that (I) (we) last saw the deceased alive on Dec 26, 1960 , and that death occurred at 1205A from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Henry V. Chase | | | 22b. DATE SIGNED 12/27/60 | | 22c. PHYSICIAN'S NAME (Type) Henry V. Chase, M.D. |
| 22d. ADDRESS East Church Street, Frederick, Maryland | | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/29/1960 | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State) Frederick, Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | 25a. RECEIVED BY REGISTRAR 44-2-660 | | 25b. REGISTRAR'S SIGNATURE William S. Huang |



13847

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13827

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|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b Years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 312 East Second Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF (Type or print) ORZULA CATHERINE CRUM | | | | 4. DATE OF DEATH Month December Day 4 Year 1960 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH January 5, 1876 | |
| 9. AGE (In years last birthday) 84 yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Mahlon B. Green | | | |
| 14. MOTHER'S MAIDEN NAME Mary Ann Hoffman | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. None | | | | 17. INFORMANT Mr. Mahlon L. Crum— Same as Item #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Symptoms DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death 5 yrs years | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that (I) (this hospital) attended the deceased from Aug 1960 to Dec 4, 1960 , that (I) (we) last saw the deceased alive on August 1960 , and that death occurred on 3 A.M. from the causes and on the date stated above | | | |
| 22a. SIGNATURE Rex R. Martin | | | | 22b. DATE SIGNED 12/6/1960 | | 22c. PHYSICIAN'S NAME (Type) Rex R. Martin, M. D. | |
| 22d. ADDRESS North Market Street, Frederick, Maryland | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | |
| 23b. DATE THEREOF Dec. 7, 1960 | | | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 25a. REC'D BY REGISTRAR DEC 8 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kenna | |



CERTIFICATE OF DEATH

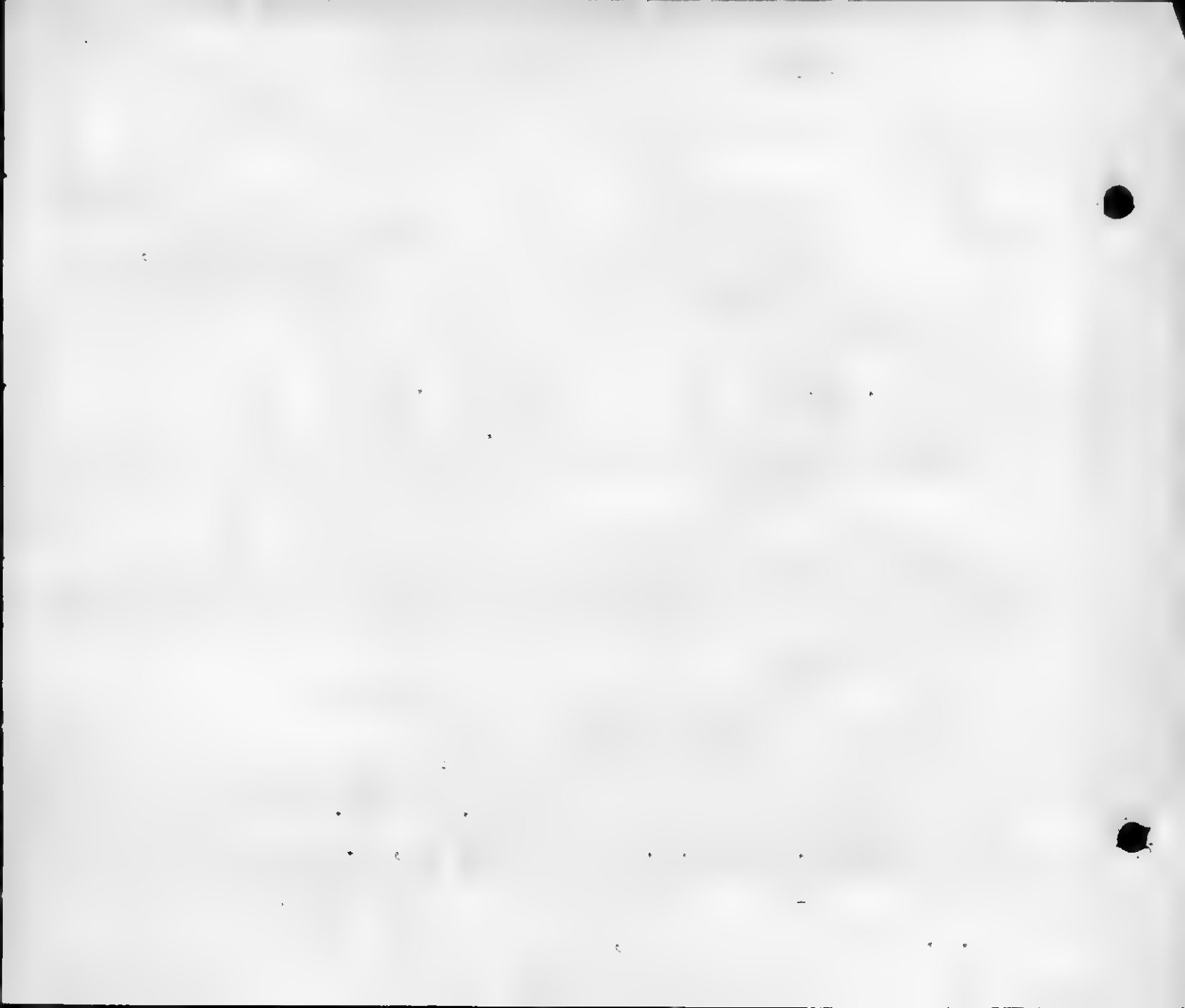
Reg. Dist. No. 13828

13848

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN IS 14 Hours | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First CARRIE Middle REBECCA Last DEGRANGE | | | | 4. DATE OF DEATH Month December Day 1 Year 1960 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11 Feb 1891 | |
| 9. AGE (In years last birthday) 69 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work | | | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Clifford S. Smith | | | | 14. MOTHER'S MAIDEN NAME America Jane King | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Lloyd S. DeGrange (Same as item #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute coronary thrombosis 4-28-60 DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 5 yrs + | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 11/30 , 19 60 , to 12/1 , 19 60 , that I last saw the deceased alive on 12/1 , 19 60 , and that death occurred at 2:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 E. Church St. DATE SIGNED 1 Dec 60 | | | | | | | |
| ACTUAL SIGNATURE Henry V Chase M. D. | | | | PHYSICIAN'S NAME (Type) Henry V. Chase, M. D. Frederick, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-3-60 | | 22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery | | 22d. LOCATION (City, town, or county) (State) Jefferson, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR DATE DEC 5 '60 | | 24b. REGISTRAR'S SIGNATURE C. L. E. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be released by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

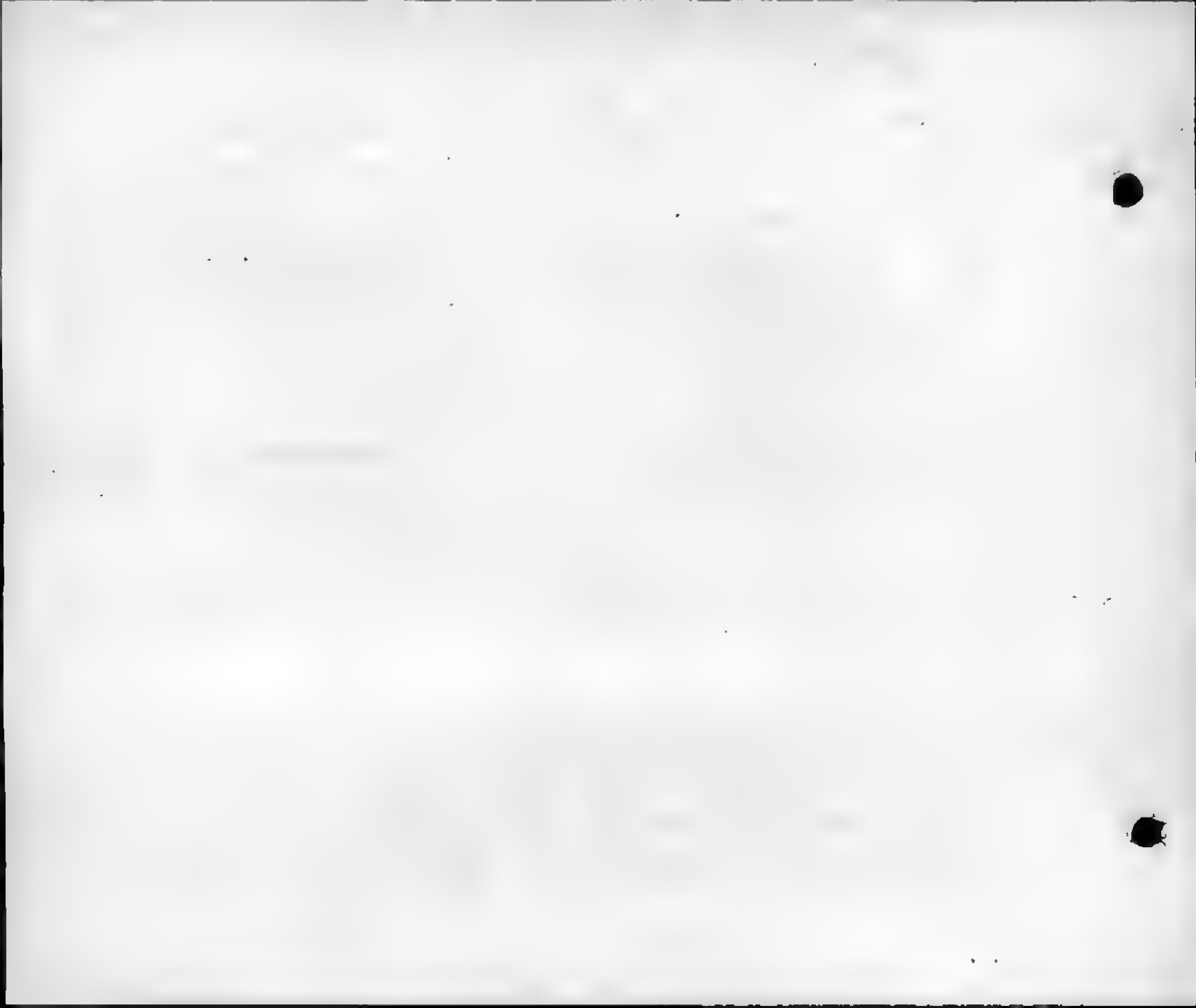
13849

 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13829

Item 8 **CERTIFICATE OF DEATH**

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b Frederick | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick New Market | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hos. | | | | | | e. STREET ADDRESS 1 | | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First JESSE Middle DONOVAN Last | | | | | | 4. DATE OF DEATH Month Dec. Day 31 Year 1960 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 5, 1897 | | 9. AGE (In years last birthday) yrs 63 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Virginia | | | | 11. BIRTHPLACE (State or foreign country) Virginia | | | |
| 12. CITIZEN OF WHAT COUNTRY? Unknown | | | | | | 13. FATHER'S NAME Unknown | | | | | |
| 14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 15. SOCIAL SECURITY NO. 217-28-7048 | | 16. INFORMANT Harry Delander, Woodbine, Md | | | | Address | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from November 1960 to Dec 31 , 1960 that (I) was last saw the deceased alive on Dec 31 , 1960 and that death occurred at 6PM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Charles S. Putnam Jr. | | | | | | M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | 22d. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b. DATE THEREOF 1-4-61 | | 23c. NAME OF CEMETERY OR CREMATORY Lisbon | | | | 23d. LOCATION (City, town, or county) (State) Lisbon, Md | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md | | | | | | 25a. REC'D BY REGISTRAR DATE JAN 4 '61 | | 25b. REGISTRAR'S SIGNATURE Chas S Putnam | | | |



CERTIFICATE OF DEATH

Reg. Dist. No.

13850

13830

| | | | |
|--|----------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | |
| c. LENGTH OF STAY IN 1b 10 Months | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 302 Middle Street | | d. STREET ADDRESS 302 Middle Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Henrietta Nettie Debra Dorsey | | 4. DATE OF DEATH Month Day Year Dec. 19 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 12-1891 |
| 9. AGE (In years lost birthday) 69 yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY ***** | |
| 11. BIRTHPLACE (State or foreign country) Frederick Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William H. Rico Sr. | | 14. MOTHER'S MAIDEN NAME Martha Penn | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO 220-30-9035A | |
| INFORMANT Louise Henry-302 Middle St. Fred. Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X DUE TO Cerebral vascular accident (b) Hypertension (c) DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years years | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11-1-1959 to 12-19-1960 that I last saw the deceased alive on 12-17-1960, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Rex Martin M.D. | | | |
| PHYSICIAN'S NAME (Type) Rex Martin | | Market St. Frederick Maryland | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 12-22-60 | 22c. NAME OF CEMETERY OR CREMATORY John Wesley | 22d. LOCATION (City, town, or county) (State) Libertytown-Fred. Co. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks 111 | | ADDRESS Frederick, Md. | |
| 24a. REC'D BY REGISTRAR DATE JAN 4 '61 | | 24b. REGISTRAR'S SIGNATURE | |



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13882

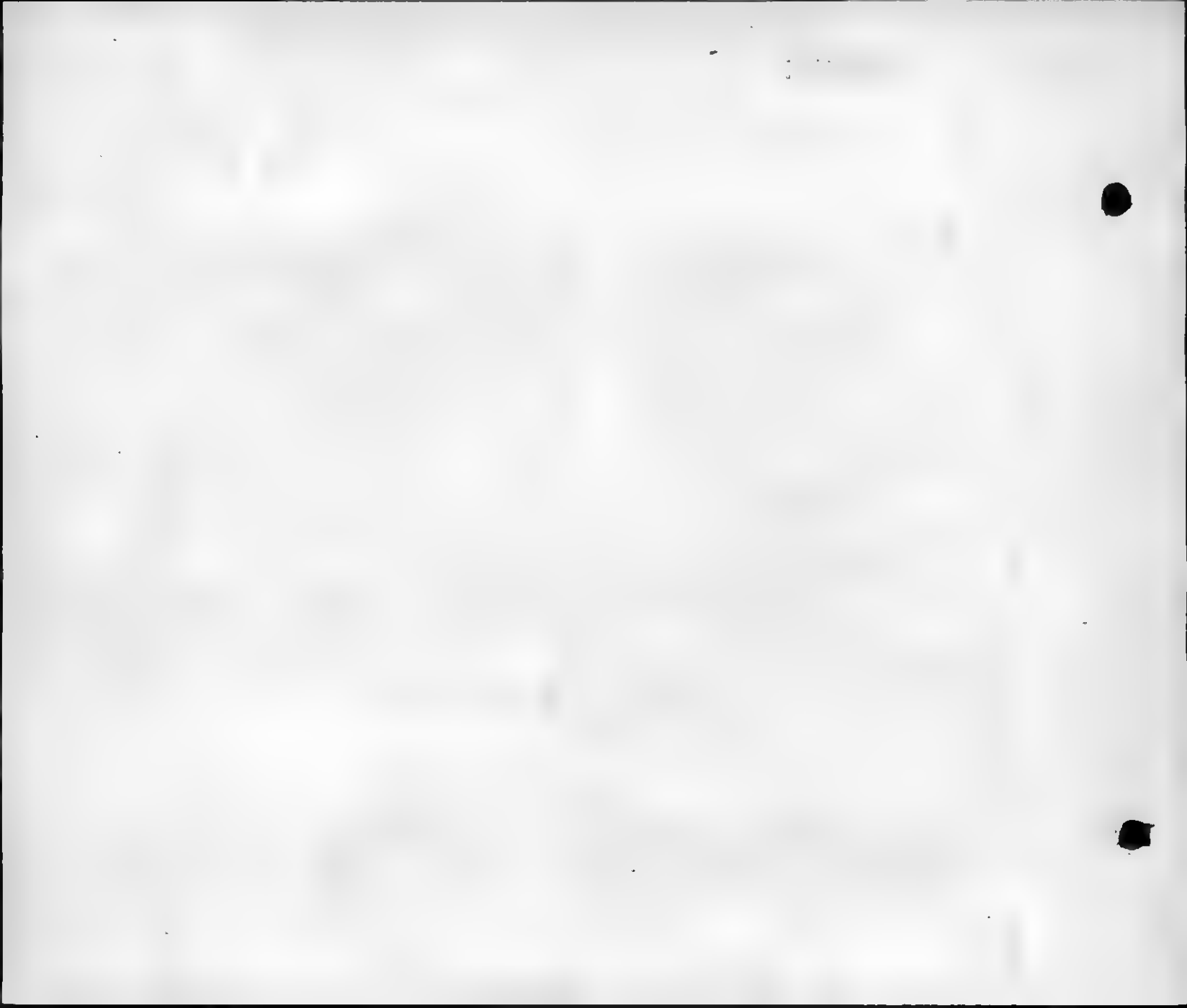
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13881

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 26</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marlintonville Route 26</u> | |
| c. LENGTH OF STAY IN 1b <u>5 yrs</u> | | d. STREET ADDRESS <u>1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>Calvin</u> Last <u>Doub</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>12</u> Year <u>1968</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 8, 1906</u> |
| 9. AGE (in years last birthday) <u>62</u> yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager Drug Co</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Pittsburg, Pa</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Pa</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Oscar E. Doub</u> | | 14. MOTHER'S MAIDEN NAME <u>Janina Johnson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO <u>213-09-8745</u> | |
| 17. INFORMANT <u>Mrs. Izorah Doub</u> | | Address <u>Mary Rd 3</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>B.O. Thomas</u> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>B.O. Thomas, M.D.</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec. 12, 1968</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>12/15/60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henny Lander & Sons, Inc</u> | | 24a. REC'D BY REGISTRAR <u>Balto 13</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneib</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

13851

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13832

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b 5 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montevue Co. Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Bessie Middle M. Last Draper | | 4. DATE OF DEATH Month 12 Day 15 Year 1960 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/22/1880 |
| 9. AGE (In years last birthday) 80 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Henry Hatne | | 14. MOTHER'S MAIDEN NAME Mary Draper | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Edgar Draper, Frederick, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) 10 yrs. | | INTERVAL BETWEEN ONSET AND DEATH 6 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1950 to Dec. 13 , 19 60 , that (I) (was) last saw the deceased alive on Dec 13 , 19 60 , and that death occurred at 11 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE H.F. Kiene | | 22b. DATE SIGNED Dec 17 1960 | |
| 22c. PHYSICIAN'S NAME (Type) H.F. KIENE MD | | 22d. ADDRESS FREDERICK MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE THEREOF 12/18/1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY St. Bethel Meth. Cemetery Frederick Co., Md. | | 23d. LOCATION (City, town, or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md | | 25a. REC'D BY REGISTRAR DEC 21 '60 | |
| 25b. REGISTRAR'S SIGNATURE William S. Klaus | | | |



13883

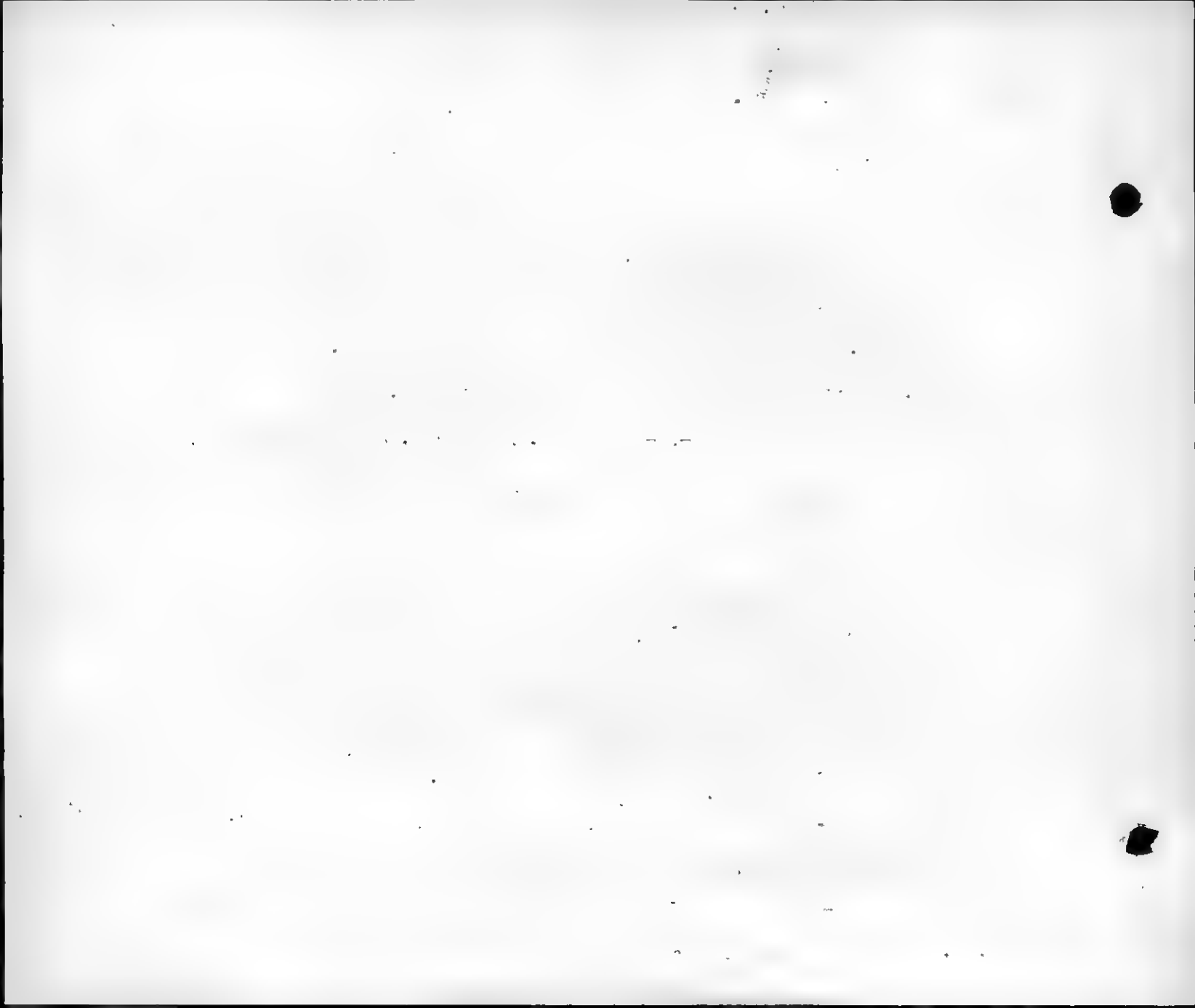
CERTIFICATE OF DEATH

Reg. Dist. No. 13833

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Ijamsville c. LENGTH OF STAY IN b. 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riggs Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 1707 Rosemont Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Margaret Middle STOKES Last ENGELBRECHT | | 4. DATE OF DEATH Month Dec Day 1 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb 18 1894 |
| 9. AGE (In years lost birthday) 1 yrs. | | 10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1 | 11. IF UNDER 24 HRS Months 1 Days 1 Hours 1 Min 1 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Cleaning Firm | 11. BIRTHPLACE (State or foreign country) Frederick, Md. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Frank M. Stokes | |
| 14. MOTHER'S MAIDEN NAME Florence V. Topper | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service,) | |
| 16. SOCIAL SECURITY NO. 217-10-9212 | | INFORMANT Address Mr. Beverly M. Angelbrecht (Same as item #2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491x DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Arteriosclerotic Heart Disease | | | INTERVAL BETWEEN ONSET AND DEATH 3 days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov 29 , 1960, to Dec 1 , 1960 that I last saw the deceased alive on Dec 1 , 1960, and that death occurred at 5:45 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Joseph Lerner M.D. | | ADDRESS (Street, city or town, state) Gaithersburg, Md DATE SIGNED 12/1/60 | |
| PHYSICIAN'S NAME (Type) Joseph Lerner | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 12-5-60 | 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland ADDRESS | | 24a. REC'D BY REGISTRAR DEC 5 '60 | 24b. REGISTRAR'S SIGNATURE Collier & Kneass |

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13852

13834

| | | | | | | | |
|---|--|---|---|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | c. LENGTH OF STAY IN 1b Since 10-15-60 | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 610 Schley Avenue | | | | e. STREET ADDRESS 610 Schley Avenue | | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First FLORENCE Middle MALINDA Last FLOOK | | | | 4. DATE OF DEATH Month December Day 12 Year 1960 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 30 July 1881 | |
| 9. AGE (In years and birthday) 79 yrs | | 10. IF UNDER 1 YEAR Months 11 Days 15 Hours 00 Min 00 | | 11. IF UNDER 24 HRS Months 00 Days 00 Hours 00 Min 00 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work | | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME George H. Tritapoe | | | | 14. MOTHER'S MAIDEN NAME Vandelia Castle | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 578-38-7607 | | 17. INFORMANT Address Howard O. Flook, Sr. (Same as item #1) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT 4-1-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH one hour |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/4 19 60 , to 12/12 19 60 , that (I) (we) last saw the deceased alive on 19 and that death occurred on 12/12 A. M., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Richard C. Reynolds, M.D. M.D. | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED 13 Dec 1960 | |
| 22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds, M.D. | | | | 22d. ADDRESS 9 E. Church St., Frederick, Md. | | | |
| 23a. BURIAL, CREMATON, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-15-60 | | 23c. NAME OF CEMETERY OR CREMATORY Union Cemetery | | 23d. LOCATION (City, town or county) (State) Burkittsville, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 25a. REC'D BY REGISTRAR DATE DEC 15 '60 | | 25b. REGISTRAR'S SIGNATURE Richard C. Reynolds | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



13884

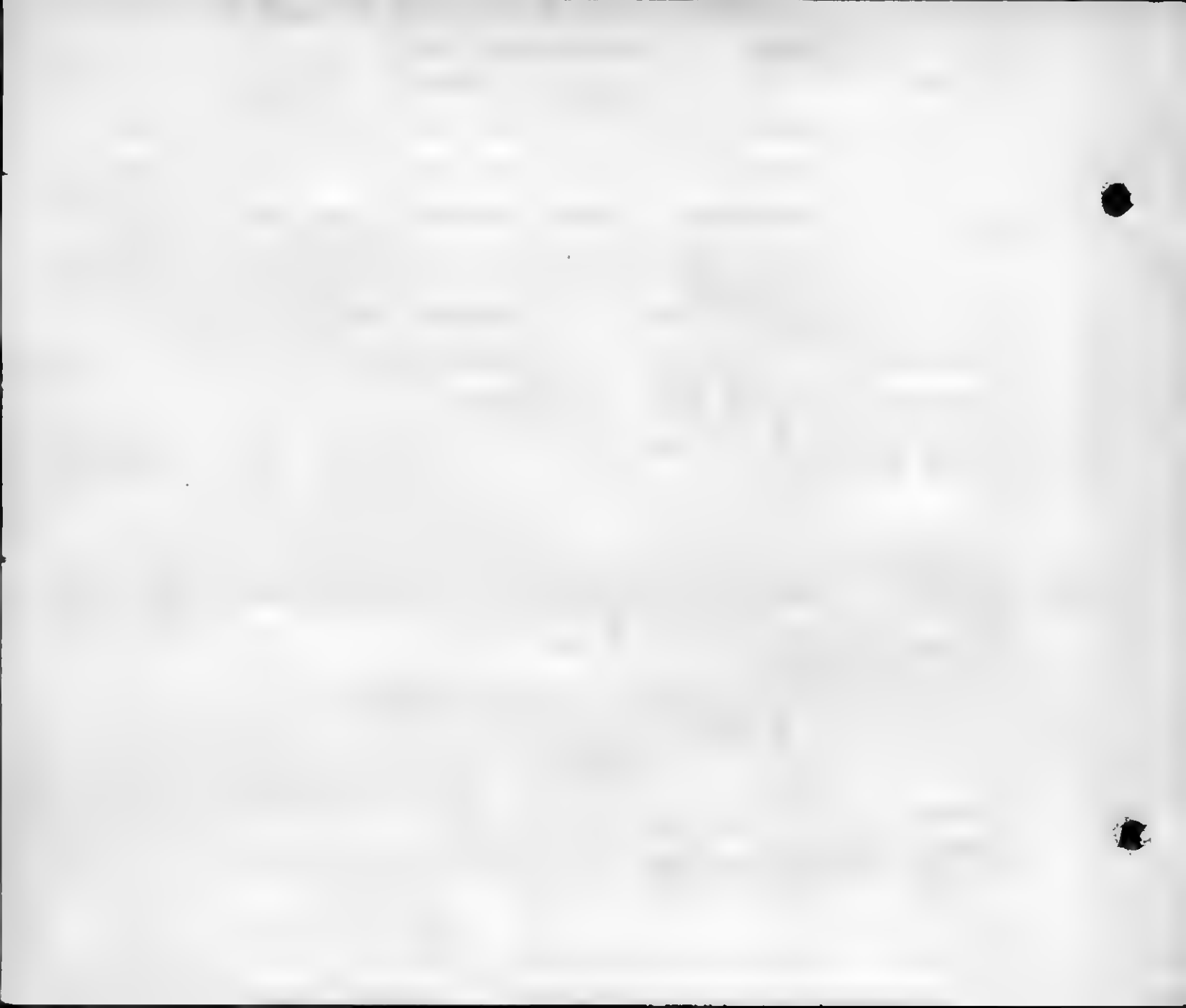
CERTIFICATE OF DEATH

Reg. Dist. No. 13835

| | | | |
|---|--------------------------------------|--|---|
| 1. PLACE OF DEATH o COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Midway</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Midway</u> | |
| c. LENGTH OF STAY IN lb <u>Life</u> | | d. STREET ADDRESS <u>1</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER CLETUS FOGLE</u> | | 4. DATE OF DEATH Month Day Year <u>Dec. 17 1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 29 1877</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Food Store Dealer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Milton Isaac Fogle</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Catherine Clark</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Mrs. Jane Dwyer, Rocky Ridge, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) (c) <u>Coronary Arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec 1</u> 19 <u>60</u> to <u>Dec 17</u> 19 <u>60</u> that I last saw the deceased alive on <u>Dec 10</u> 19 <u>60</u> , and that death occurred at <u>9</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>J. H. Mission</u> M.D. | | DATE SIGNED <u>11 Mon Dec 19 1960</u> | |
| PHYSICIAN'S NAME (Type) <u>J. H. Mission</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12/20/60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Naughton</u> | 22d. LOCATION (City, town, or county) (State) <u>M. Frederickson Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Barton</u> | | ADDRESS <u>Walkersville, Md</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>DEC 23 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. C. Barton</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13853

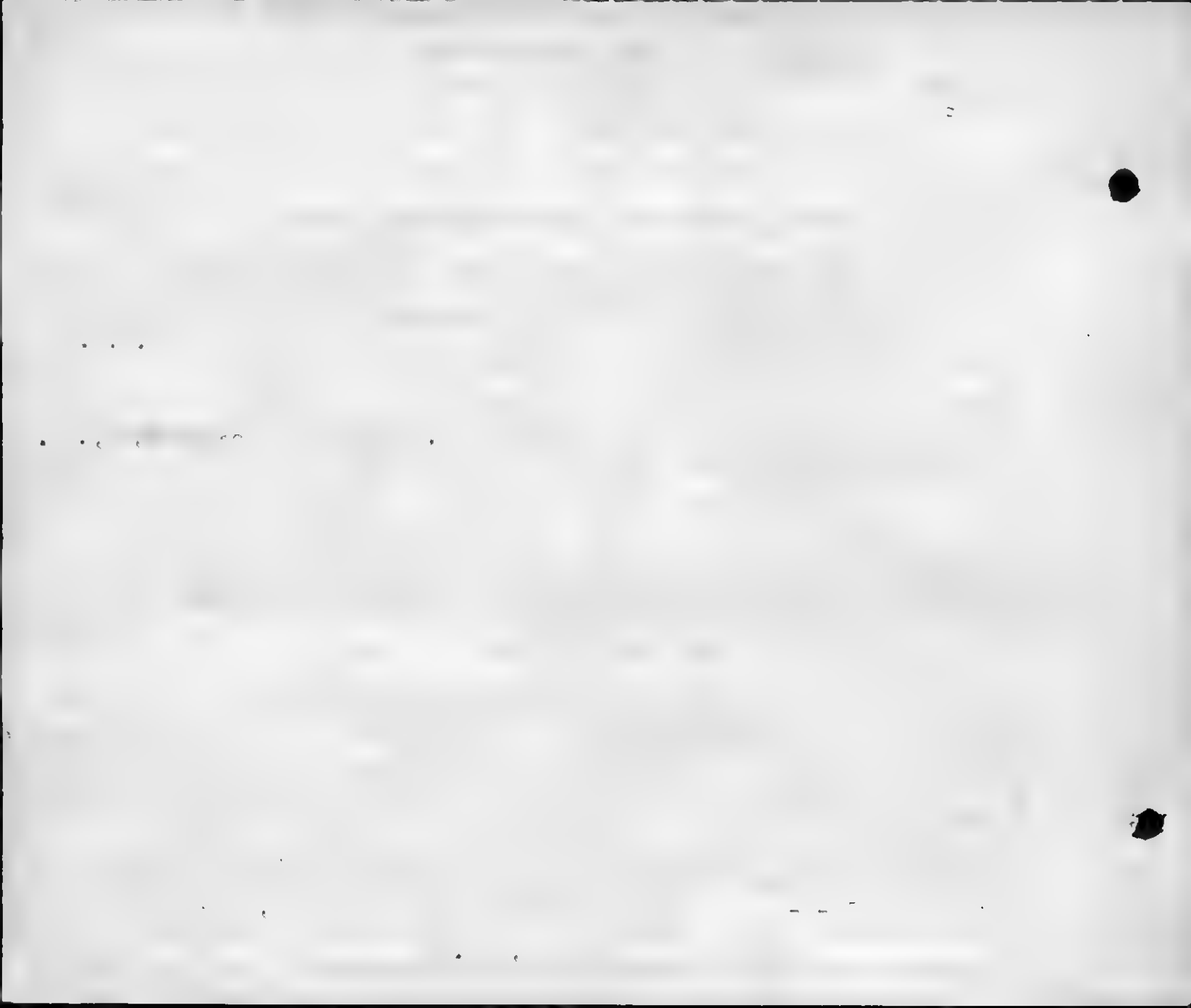
CERTIFICATE OF DEATH

13836

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X ROCK RIDGE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>STEVEN</u> Middle <u>CRAIG</u> Last <u>FRUSHOUR</u> | | 4. DATE OF DEATH <u>DECEMBER</u> Month <u>3</u> Day <u>1960</u> Year | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 1, 1960</u> |
| 9. AGE (In years last birthday) yrs <u>1</u> | | IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u> | IF UNDER 24 HRS. Hours <u>10</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> |
| 13. FATHER'S NAME <u>Charles Robert Frushour</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY GERALDINE BREEDEN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Charles R. Frushour</u> | | Address <u>Rocky Ridge, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 750 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Encephalitis</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>December 1, 1960</u> , to <u>December 3, 1960</u> , that I last saw the deceased alive on <u>December 3, 1960</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D. | | | |
| PHYSICIAN'S NAME (Type) <u>DR. F. J. Heldrick</u> | | Frederick Medical Center | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12-3-60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Thurmont, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Thurmont, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DEC 6 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

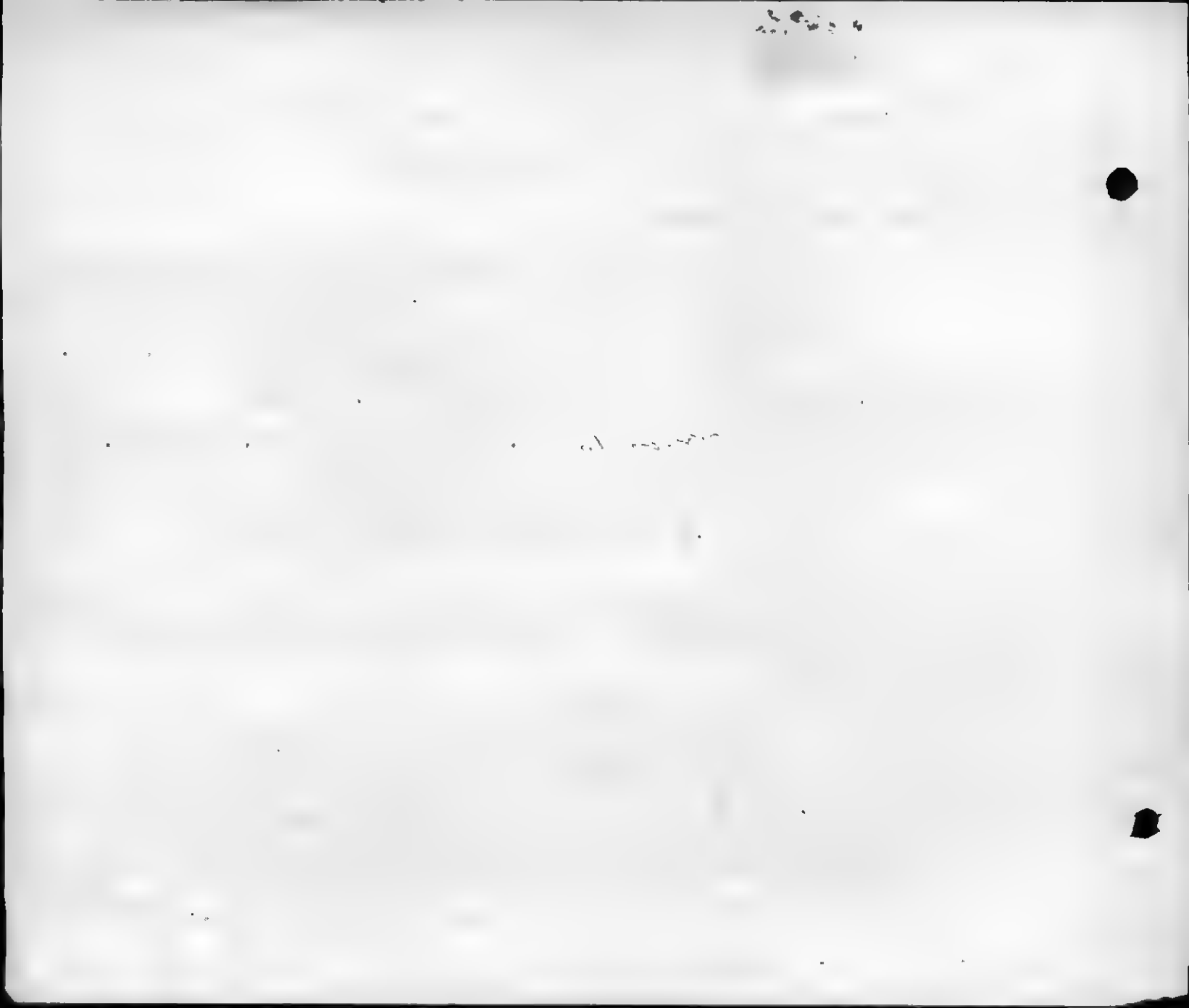
13854

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13837

| | | | |
|--|------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) James C. Gamber | | 4. DATE OF DEATH Dec 27 1960 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 30, 1886 |
| 9. AGE (In years, months, days, hours, minutes) 74 | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) U. S. A. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME George W. Gamber | | 14. MOTHER'S MAIDEN NAME Christie A. Gosnell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO 213-12-2043 | |
| 17. INFORMANT Mrs. Viola Norwood, Mt. Airy, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure 422.0 DUE TO Anteriorly located heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) 3 year (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 weeks | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 12/26 1960 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/26 , 1960, to 12/27 , 1960, that (I) (we) last saw the deceased alive on 12/26 , 1960, and that death occurred at A. M. , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Henry V. Chase | | 22b. DATE SIGNED 12-27-60 | |
| 22c. PHYSICIAN'S NAME (Type) Henry V. Chase | | 22d. ADDRESS 4 E. Church St. Frederick Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-30-1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Taylorville Cemetery | | 23d. LOCATION (City, town, or county) (State) Carroll Co., Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland | | 25a. REC'D BY REGISTRAR DEC 29 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Hana | | | |

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13885

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13838

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.F.D.#2 | | c. LENGTH OF STAY IN 1b Minutes | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Overpass-U.S.#240&New Design Road | | e. STREET ADDRESS 122 West Church Street | |
| 3. NAME OF DECEASED (Type or print) First BRUCE Middle GREGORY Last GREGORY | | 4. DATE OF DEATH Month December Day 28 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 13, 1903 |
| 9. AGE (In years and birthday) 57 yrs. | | 10. IF UNDER 1 YEAR Months 5 Days 1 | 11. IF UNDER 24 HRS Hours 1 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Exct. | | 10b. KIND OF BUSINESS OR INDUSTRY Tire Company | |
| 11. BIRTHPLACE (State or foreign country) Michigan | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Eugene Gregory | | 14. MOTHER'S MAIDEN NAME Della Allen | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 298-01-4361 | |
| 17. INFORMANT Mrs. Ruth E. Gregory-Same as Item #2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURED SKULL 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) CRUSHED CHEST (c), stating the underlying cause lost. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH Instant | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Auto Ran Off Road-Striking Abutment of OverPass | |
| 20c. TIME OF INJURY Month, Day, Year 11 Hour XX p.m. 12/28/ 19 60 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | | 20f. (City or town) (County) (State) Frederick, Frederick, Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE B. O. Thomas | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) B. O. Thomas, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 1/3/1961 | |
| 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory | | 22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |
| 24a. REC'D BY REGISTRAR DATE JAN 4 '61 | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-10. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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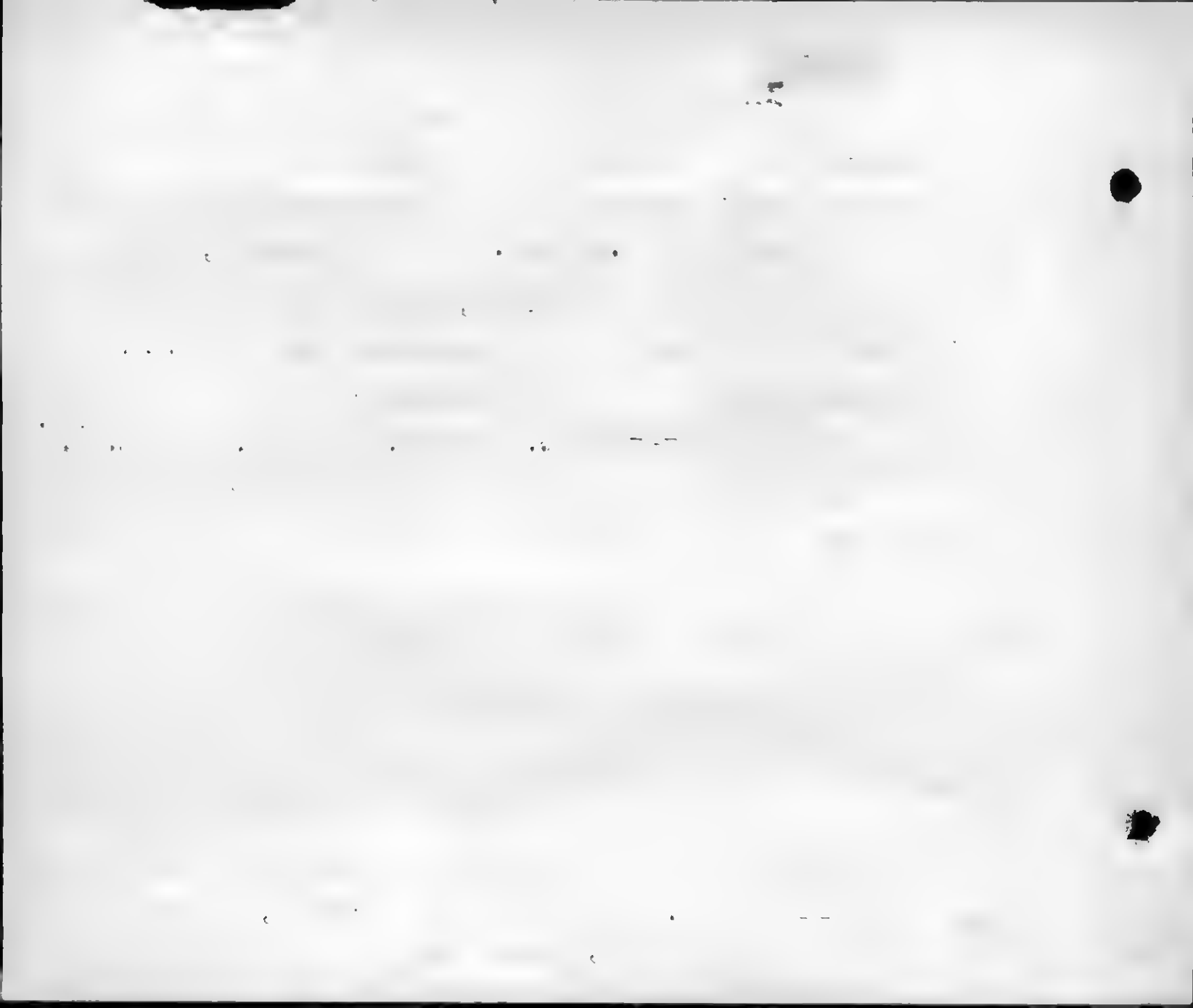
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13839

13855

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b Lifetime | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First EDWARD Middle Allen Last GROVE | | | | 4. DATE OF DEATH Month December Day 2 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 19, 1923 | |
| 9. AGE (in years lost birthday) 37 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer | | 11. BIRTHPLACE (State or foreign country) Frederick, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Preston Grove | | | | 14. MOTHER'S MAIDEN NAME Adelia Miller | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 212-14-7964 | | 17. INFORMANT Mrs. Beatrice E. Grove 202 E. Church St. Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with DUE TO (b) generalized metastases DUE TO (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STOTING THE UNDERLYING CAUSE LAST. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 mo. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a m p m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/1 19 60 , to 12/2 19 60 , that (I) (we) last saw the deceased alive on 12/2 19 60 , and that death occurred at 9:30 A.M. from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Henry V. Chase | | | | 22b. ADDRESS 4 E. Church St Frederick, Md | | 22c. DATE 2 Dec 60 | |
| 22c. PHYSICIAN'S NAME (Type) Henry V. Chase | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-5-1960 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Gail | | | | 25a. REC'D BY REG-STRAR DEC 5 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



13840

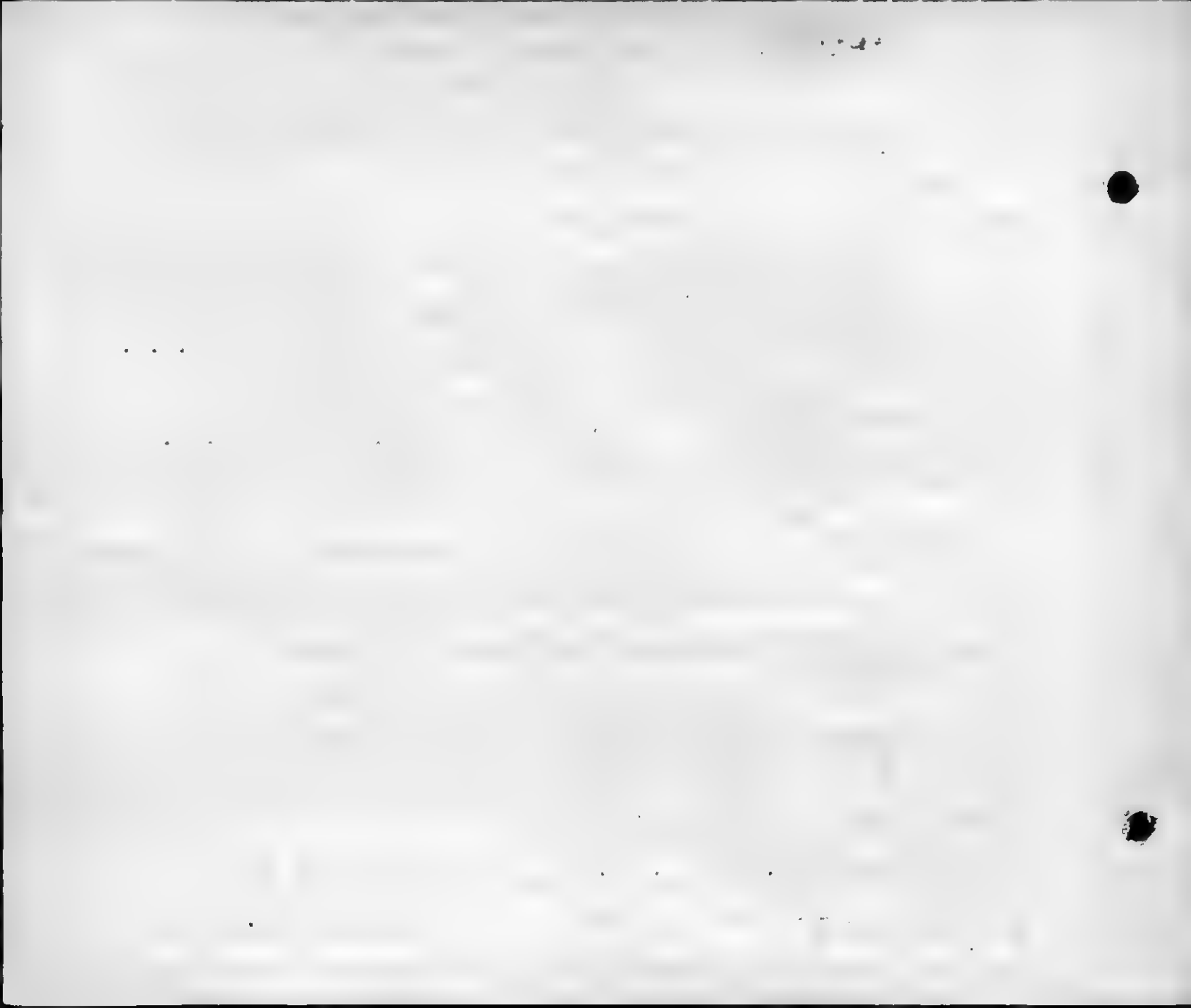
Reg. Dist. No.

| | | | | | |
|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick | | 2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital | | d. STREET ADDRESS 1209 A Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ESTELLE | | First Middle Last HARRIS | | 4. DATE OF DEATH Month Day Year DEC 6 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 27 AUG 1889 | 9. AGE (In years last birthday) 71 yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Harry Whitter | | 14. MOTHER'S MAIDEN NAME Elizabeth Krieg | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Evelyn Wellen, Buckeystown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYELOID LEUKEMIA 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from OCT 1952 to 6 DEC 1960 , that I last saw the deceased alive on 6 DEC 1960 , and that death occurred at 10:45 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick, Md. DATE SIGNED 12/7/60 | | | | | |
| ACTUAL SIGNATURE Charles H. Conley, Jr. | | M.D. Professional Bldg | | | |
| PHYSICIAN'S NAME (Type) CHARLES H. CONLEY, JR. | | Frederick, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 12-9-1960 | 22c. NAME OF CEMETERY OR CREMATORY Monocacy | 22d. LOCATION (City, town, or county) | (State) Bealsville, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. H. T. H. | | ADDRESS Brunswick, Maryland | | 24a. REC'D BY REGISTRAR DATE DEC 12 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55



13886

CERTIFICATE OF DEATH

Reg. Dist. No.

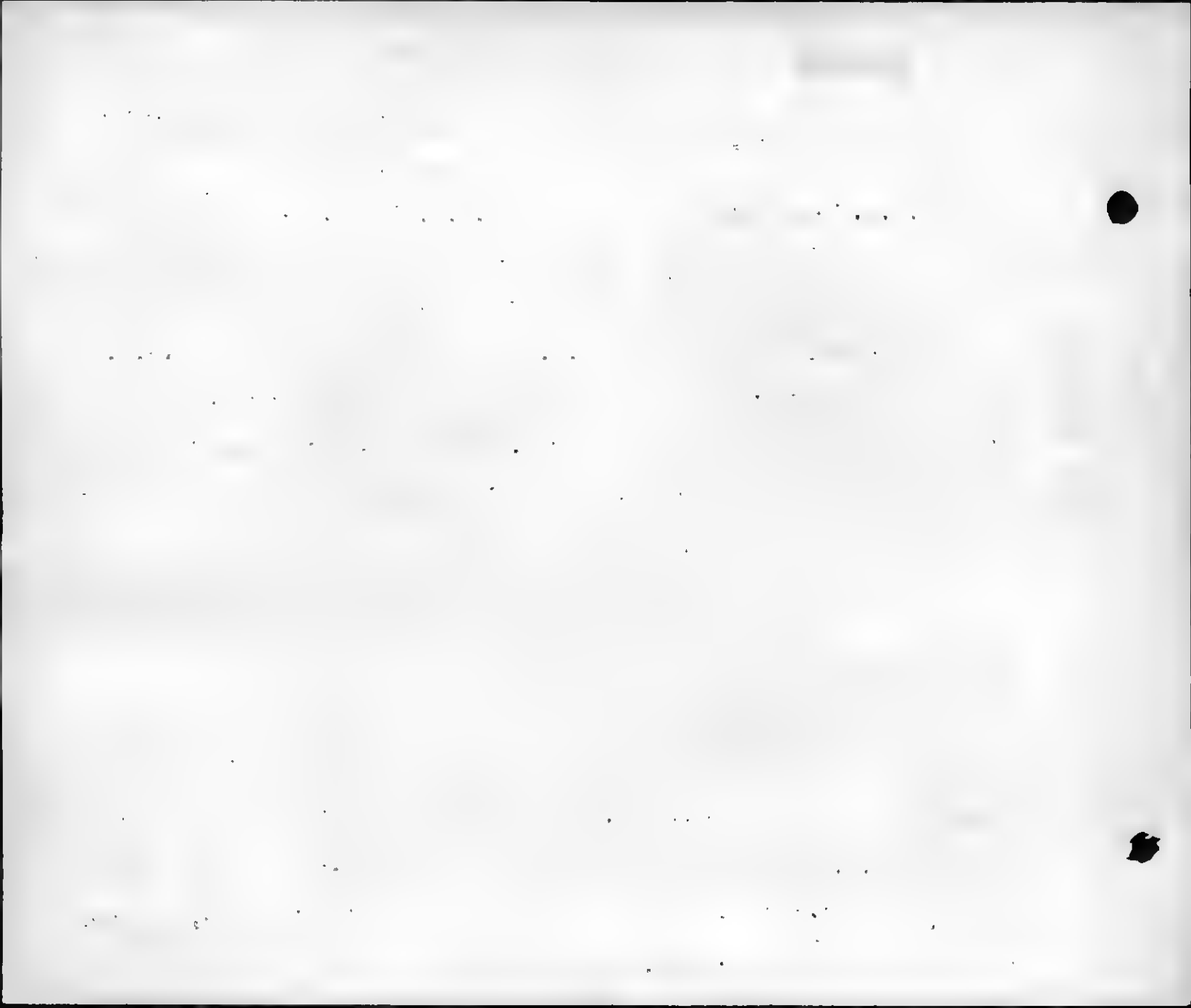
| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Petersville | | c. LENGTH OF STAY IN 1b X Petersville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Knoxville | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First John Middle Robert Last Hoar | | 4. DATE OF DEATH Month 12 Day 3 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-17-1896 |
| 9. AGE (In years last birthday) yrs 64 | | 10. IF UNDER 1 YEAR Months 6 Days 4 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MATERIAL DISTRIBUTOR B.&O | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frank Hoar | | 14. MOTHER'S MAIDEN NAME Ida Merriman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) World War 1 | | 16. SOCIAL SECURITY NO. Mrs. Olive Hoar, Knoxville, Maryland | |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Advanced cerebral arteriosclerosis DUE TO Seriously, advanced Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Seriously, advanced DUE TO (c) Seriously, advanced | | INTERVAL BETWEEN ONSET AND DEATH 3-18 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11-1-1960 to 12-3-1960 that I last saw the deceased alive on 12-3-1960 and that death occurred at 12:00 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE C.E. Pruitt M.D. | | ADDRESS (Street, city or town, state) Brunswick Maryland DATE SIGNED 12-8-60 | |
| PHYSICIAN'S NAME (Type) C.E. Pruitt | | 22. LOCATION (City, town, or county) (State) Brunswick Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/5/1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY Saint Marks | | 22d. LOCATION (City, town, or county) (State) Petersville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. Hoar ADDRESS Brunswick, Maryland | | 24a. REC'D BY REGISTRAR DEC 12 '60 24b. REGISTRAR'S SIGNATURE Clara S. Hume | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained by our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2 57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13887 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13842

| | | | |
|--|---------------------------|--|--------------------------------------|
| 1 PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New-Market</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New-Market</u> | |
| c. LENGTH OF STAY IN 1b <u>15 years</u> | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | |
| e. STREET ADDRESS | | f. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Lavinia P. Holland</u> | | 4. DATE OF DEATH <u>December 28 1960</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 7 1888</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs | | 10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick Co</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William H Pryor</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary L Hackey</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO <u>579-07-2266</u> | |
| 17. INFORMANT <u>Mary J Beach, New-Market, Md</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>15 minutes</u> DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>B.O. Thomas</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>B.O. Thomas, MD</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>DEC 28, 1960</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>DEC 30-60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>SIMPSON CHAPEL</u> | | 22d. LOCATION (City, town, or county) (State) <u>NEW MARKET MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lucian K. Falconer New-Market</u> | | 24a. REC'D BY REGISTRAR <u>DATE JAN 4 '61</u> | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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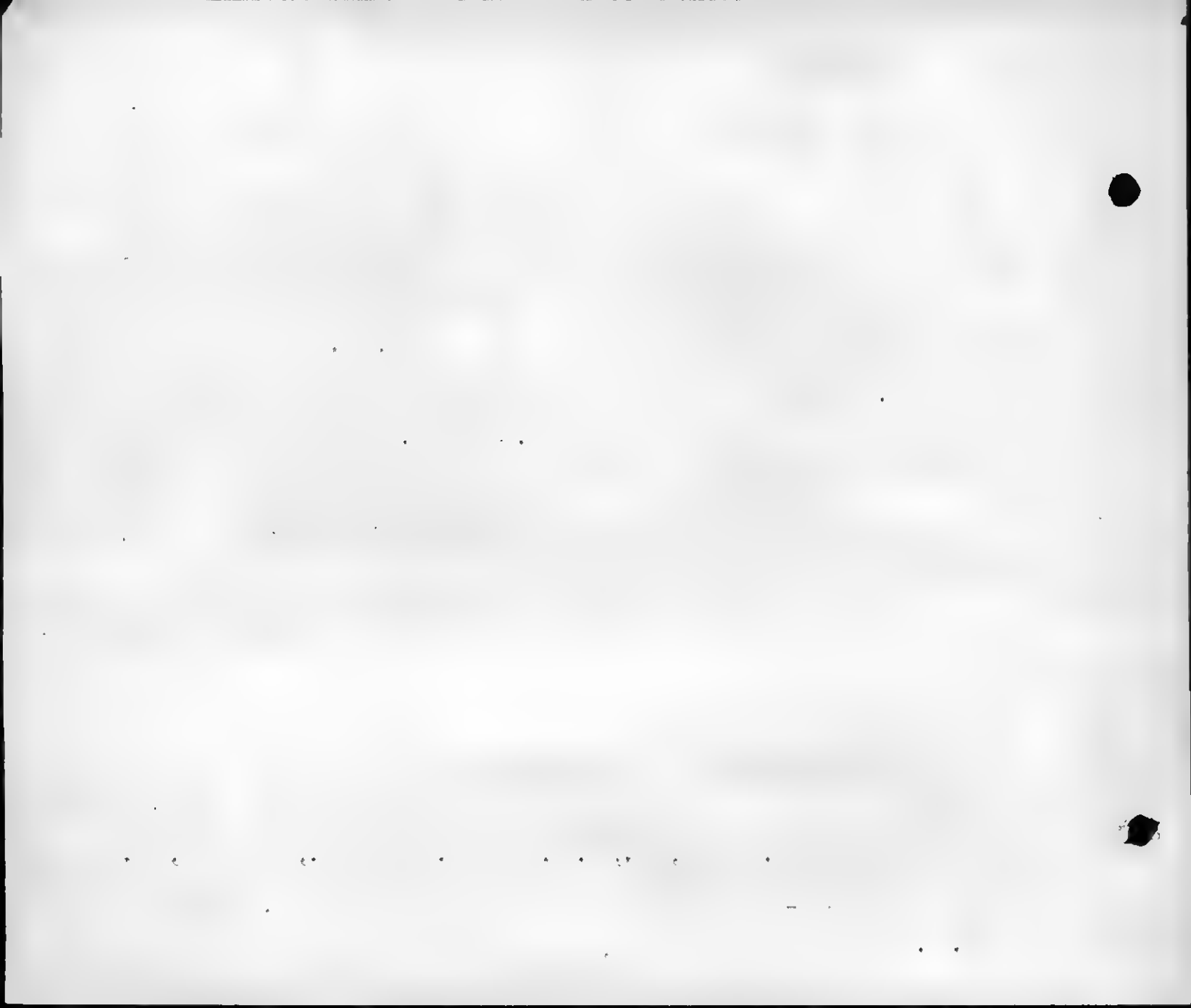
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13888

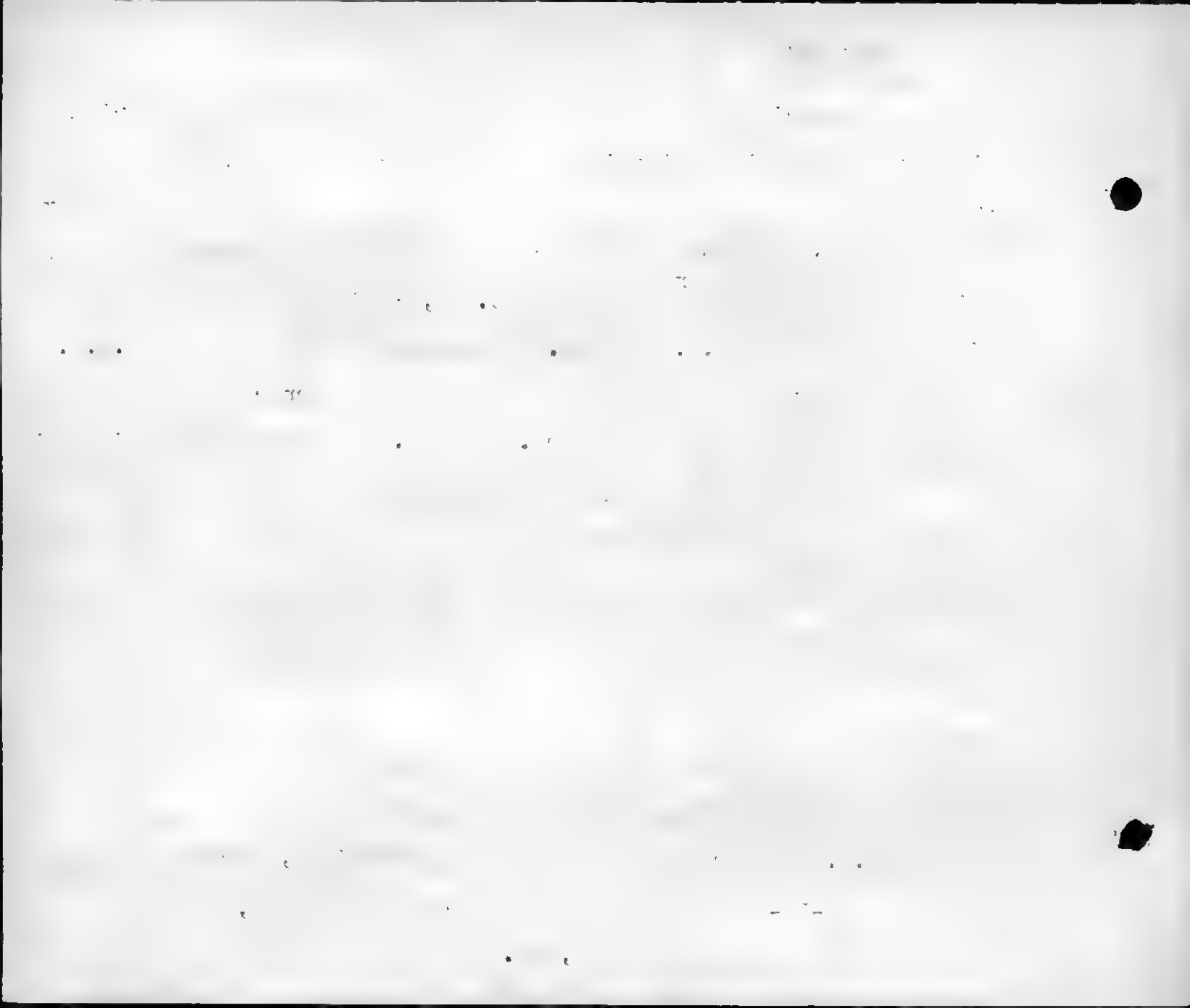
13843

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|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown | | | c. LENGTH OF STAY IN 1b Since-1949 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last DAVID EDWARD KANODE | | | | 4. DATE OF DEATH Month Day Year December 27, 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 20 July 1885 | |
| 9. AGE (In years last birthday) 75 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | 11. BIRTHPLACE (State or foreign country) Park Mills, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles E. Kanode | | | | 14. MOTHER'S MAIDEN NAME Hester Zimmerman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Carrie V. Kanode (Same as item #1) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420 DUE TO (b) Arterio-sclerotic heart dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 hours 10+ yrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1947 to Dec 60 , that (I) (we) last saw the deceased alive on 30 DEC 1960 and that death occurred at 5 A M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Charles H. Conley, Jr. M.D. | | | | 22b. DATE SIGNED 28 Dec 1960 | | 22c. PHYSICIAN'S NAME (Type) Charles H. Conley, Jr., M. D. | |
| 22d. ADDRESS 228 N. Market St., Frederick, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-30-60 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 25a. REC'D BY REGISTRAR DATE DEC 30 '60 | | 25b. REGISTRAR'S SIGNATURE Charles E. Kline | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
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| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|---------------------------|--|---|---|--|--|---|---------------------------------------|---|--|
| 13889 | | | | | 13844 | | | | | | |
| 1 PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walkersville rural | | | c. LENGTH OF STAY IN 1b Lifetime | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Walkersville rural | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Own Home | | | | | e. STREET ADDRESS / | | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Jacob Henry Kauffman | | | | | 4. DATE OF DEATH Month Day Year December 9 19 60 | | | | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 24, 1882 | | 9. AGE (In years last birthday) 78 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lime Burner | | | 10b. KIND OF BUSINESS OR INDUSTRY F.R. Lime Co. | | | 11 BIRTHPLACE (State or foreign country) Maryland | | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Jacob Kauffman | | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Starner | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) N | | | 16. SOCIAL SECURITY NO | | 17 INFORMANT Mrs. Daisy I. Kauffman Walkersville RD1 | | | | | | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 33 1 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>about 3 weeks</u> <u>usual years</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21 I certify that (I) (this hospital) attended the deceased from July 1957 to Dec. 9, 1960, that (I) (we) last saw the deceased alive on Dec. 6, 1960, and that death occurred at 7:45 PM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE E. A. Dettbarn | | | | | 22b. DATE SIGNED Dec. 10/60 | | | 22c. PHYSICIAN'S NAME (Type) E. A. Dettbarn | | 22d. ADDRESS Walkersville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | | 23b. DATE THEREOF 12-12-60 | | 23c. NAME OF CEMETERY OR CREMATORY Lewistown Cemetery | | | 23d. LOCATION (City, town, or county) (State) Lewistown, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Greager | | | | | ADDRESS Thurmont, Md. | | 25a. REC'D BY REGISTRAR DATE DEC 13 '60 | | 25b. REGISTRAR'S SIGNATURE | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13845

13857

| | | | | | | | |
|---|---|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Julie</u> Middle <u>Lynn</u> Last <u>Kennedy</u> | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1960</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 15, 1960</u> | 9. AGE (In years last birthday) yrs. <u>15</u> | IF UNDER 1 YEAR Months <u>15</u> Days <u>33</u> | IF UNDER 24 HRS. Hours <u>33</u> Min <u>33</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — | | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | |
| 13. FATHER'S NAME <u>Richard Linwood Kennedy</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CAROL ANN Fagan</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT <u>Mother</u> | | Address <u>SAME</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia, separate of influenza</u> DUE TO (c) <u>id-day</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>id-day</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) <u>Frederick</u> | (County) <u>Frederick</u> (State) <u>Maryland</u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec 15</u> 19 <u>60</u> to <u>Dec 16</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Dec 15</u> 19 <u>60</u> , and that death occurred at <u>11:00</u> A. M. from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE <u>Bernard O. Thomas, M. D.</u> | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED <u>12/16/60</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Bernard O. Thomas, M. D.</u> | | 22d. ADDRESS <u>Frederick, Md.</u> | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>12-17-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u> | | 23d. LOCAT ON (City, town, or county) (State) <u>Frederick, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>DEC 19 '60</u> | | 25b. REGISTRAR'S SIGNATURE <u>W. L. S. S. S.</u> | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

20612-1XV4



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

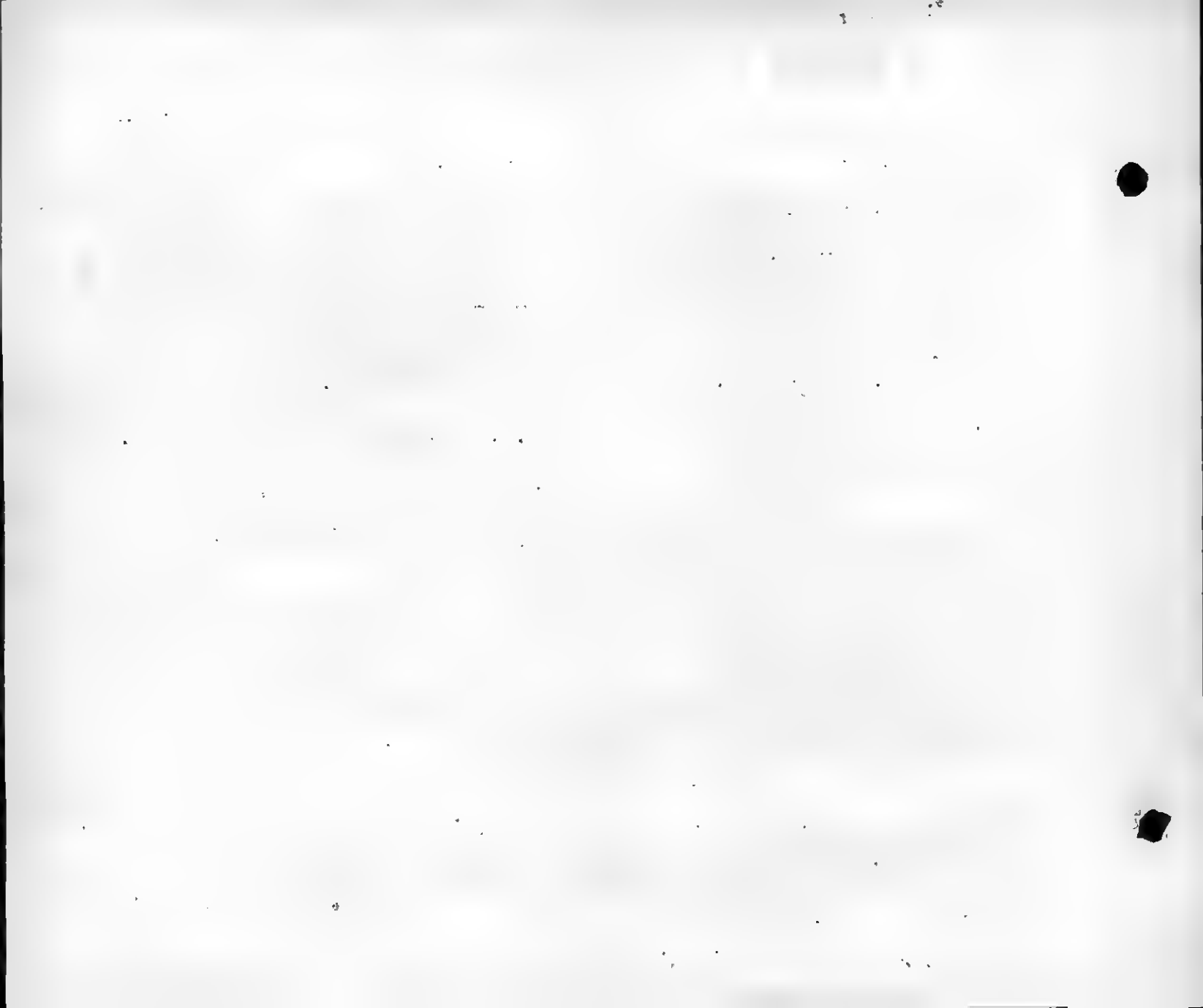
VS A15 (4)
15M 9/58

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | |
|--|--|----------------------------------|--|---|---|--------------------------------------|--|---|---|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| Reg. Dist. No. 13846 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) o. STATE Maryland b. COUNTY Frederick | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick | | | | | c. LENGTH OF STAY IN 1b Life | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 South Maryland Avenue | | | | | e. STREET ADDRESS 8 South Maryland Avenue | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Charles Middle Burton Last Langley | | | | | 4. DATE OF DEATH Month 12 Day 25 Year 19 60 | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-14-1905 | | 9. AGE (In years last birthday) yrs 55 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME John T. Langley | | | | | 14. MOTHER'S MAIDEN NAME Leona House | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | | | | INFORMANT Mrs. Maxine Langley, Brunswick, Md. | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 224X DUE TO Rathke's pouch cyst. | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 18. INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that I attended the deceased from 12-25-1960 to 12-27-1960 , that I lost saw the deceased alive on 12-27-1960 , and that death occurred at 11:00 P.M. from the causes and on the date stated above | | | | | | | | | | | |
| ADDRESS (Street, city or town, state) Brunswick, Md. DATE SIGNED 12-27-60 | | | | | | | | | | | |
| ACTUAL SIGNATURE C.E. Pruitt M.D. Brunswick, Md. | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) C.E. Pruitt | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | | |
| 22b. DATE THEREOF 12-28-1960 | | | | | | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Union | | | | | | | | | | | |
| 22d. LOCATION (City, town, or county) (State) LOVETTSVILLE, VIRGINIA | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Brundage Brunswick, Maryland | | | | | | | | | | | |
| 24a. REC'D BY REGISTRAR DATE DEC 30 '60 | | | | | | | | | | | |
| 24b. REGISTRAR'S SIGNATURE Orlino S. Knapp | | | | | | | | | | | |

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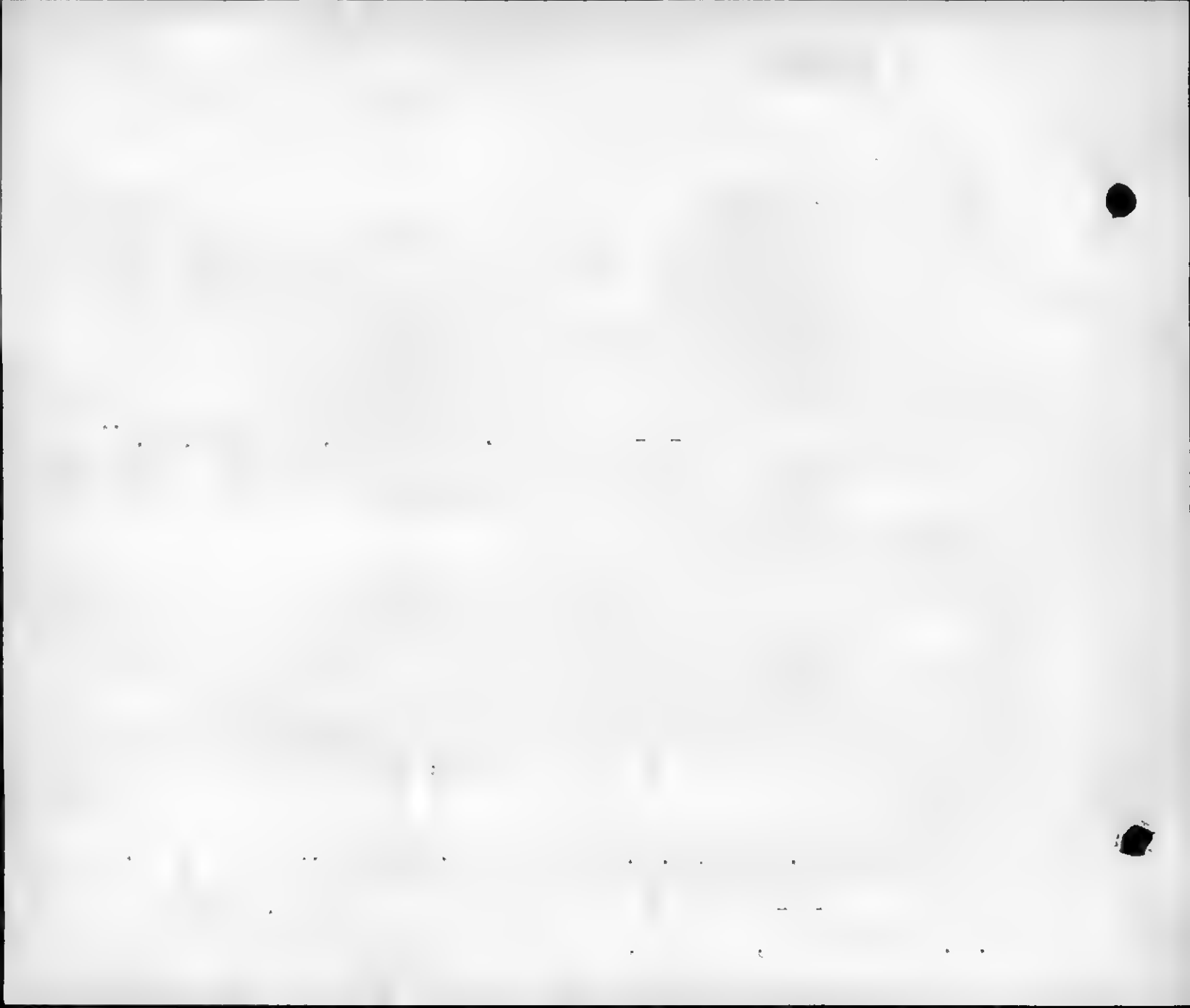


VR A1S (4)
15M 9/59

13890

13847

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|--|----------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown-Rural | | c. LENGTH OF STAY IN 1b 3 Months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Valley View Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MICHAEL Middle IRVING Last LIPPY | | 4. DATE OF DEATH Month December Day 15 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 31 Oct 1878 |
| 9. AGE (In years last birthday) 82 yrs | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant | | 10b. KIND OF BUSINESS OR INDUSTRY Owner of Business | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Michael Lippy | | 14. MOTHER'S MAIDEN NAME Ellen Myers | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-32-7186 | |
| 17. INFORMANT Miss E. Louise Lippy, | | Address 600-A Taney Ave., Frederick, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 1956 , to 12/16 1960 , that (I) (we) last saw the deceased alive on 12/15 1960 , and that death occurred at 12:05 A M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE James B. Thomas | | 22b. DATE 16 Dec 1960 | |
| 22c. PHYSICIAN'S NAME (Type) James B. Thomas, M. D. | | 22d. ADDRESS 228 N. Market St., Frederick, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 12-17-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 25a. REC'D BY REGISTRAR DATE DEC 19 '60 | |
| 25b. REGISTRAR'S SIGNATURE J. S. Kraus | | | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

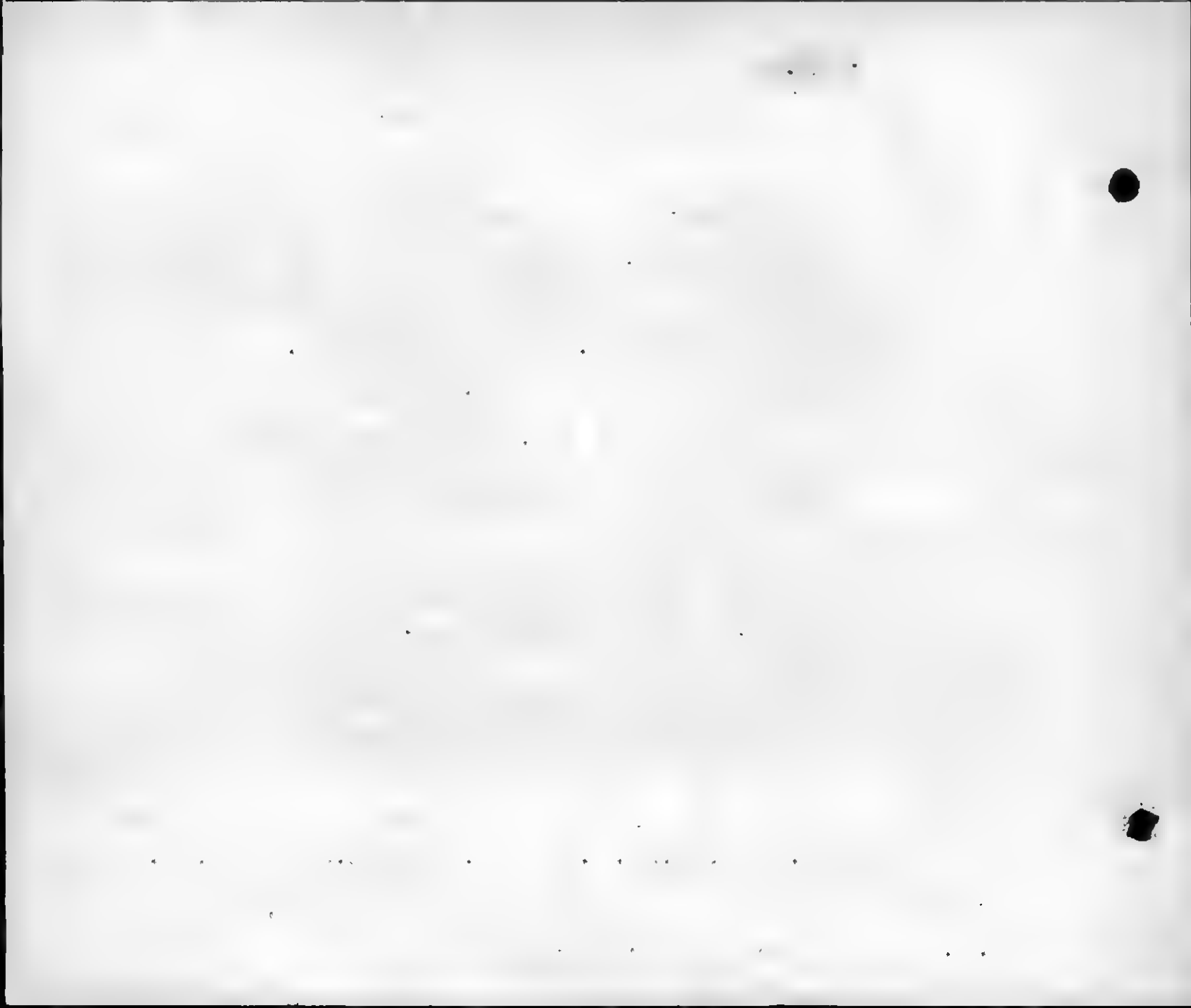
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13848

13858

CERTIFICATE OF DEATH

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | | | e. STREET ADDRESS 221 East Patrick Street | | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First ROBERT Middle M. Last MacDOUGAL | | | 4. DATE OF DEATH Month December Day 27 Year 1960 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 28 March 1887 | | 9. AGE (in years last birthday) 73 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Trainmen | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad Co. | | 11. BIRTHPLACE (State or foreign country) Shelbyville, Tenn. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Alexander MacDougal | | | | 14. MOTHER'S MAIDEN NAME Floretta Hobbs | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. Gladys James MacDougal (Same as item #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Infarction of right basal ganglia of aortic aneurysm | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 days |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 15 1956 to Dec 27 1960 , that (I) last saw the deceased alive on Dec 27 1960 , and that death occurred at 6 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Henry V. Chase | | | | 22b. DATE SIGNED 28 Dec 1960 | | 22c. PHYSICIAN'S NAME (Type) Henry V. Chase, M.D. | |
| 22d. ADDRESS 4 E. Church St., Frederick, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-30-60 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 25a. REC'D BY REGISTRAR DATE DEC 30 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur L. H... | |



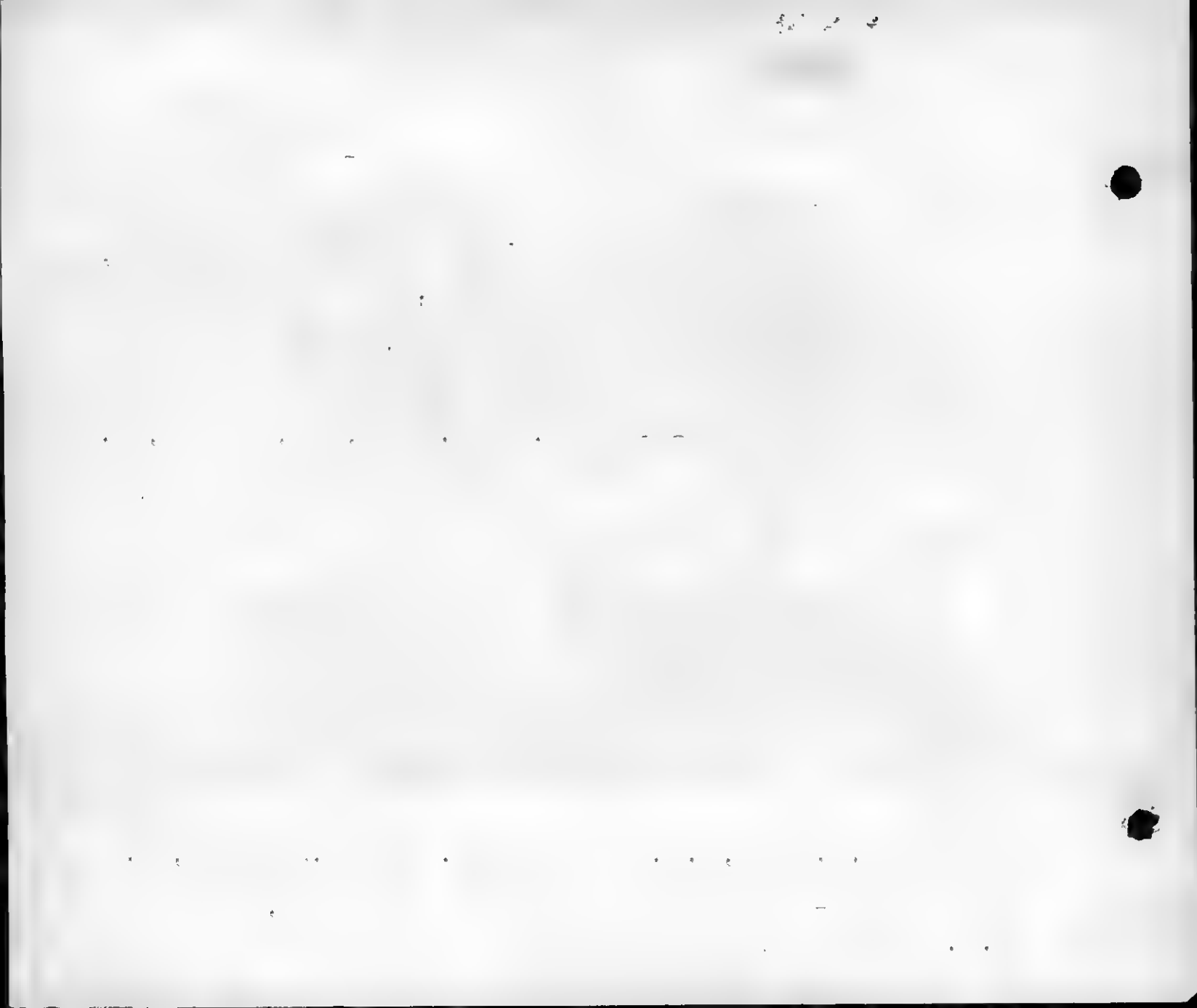
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13849

13859

| | | | | | | | |
|--|--|---|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | c. LENGTH OF STAY IN 1b 4 Hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#1 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | | | d. STREET ADDRESS 1 McKaig | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle FREDERICK Last MASSER | | | | 4. DATE OF DEATH Month December Day 15 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12 Oct 1871 | |
| 9. AGE (In years last birthday) 89 yrs. | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS Months Days Hours Min | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm Owner | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Frederick Masser | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Klipp | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO 217-18-7712 | | 17. INFORMANT Mr. Paul G. Masser, RD#4, Frederick, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO _____ (c) DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH minutes | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a m. p m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 1960 to Dec 15 1960 that (I) (we) last saw the deceased alive on Dec 15 1960 and that death occurred at 8:30P M, from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE B. O. Thomas M.D. | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE 19 Dec 1960 | |
| 22c. PHYSICIAN'S NAME (Type) B. O. Thomas, M. D. | | | | 22d. ADDRESS 228 N. Market St., Frederick, Md. | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-19-1960 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE DEC 21 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Carlton L. Thomas</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



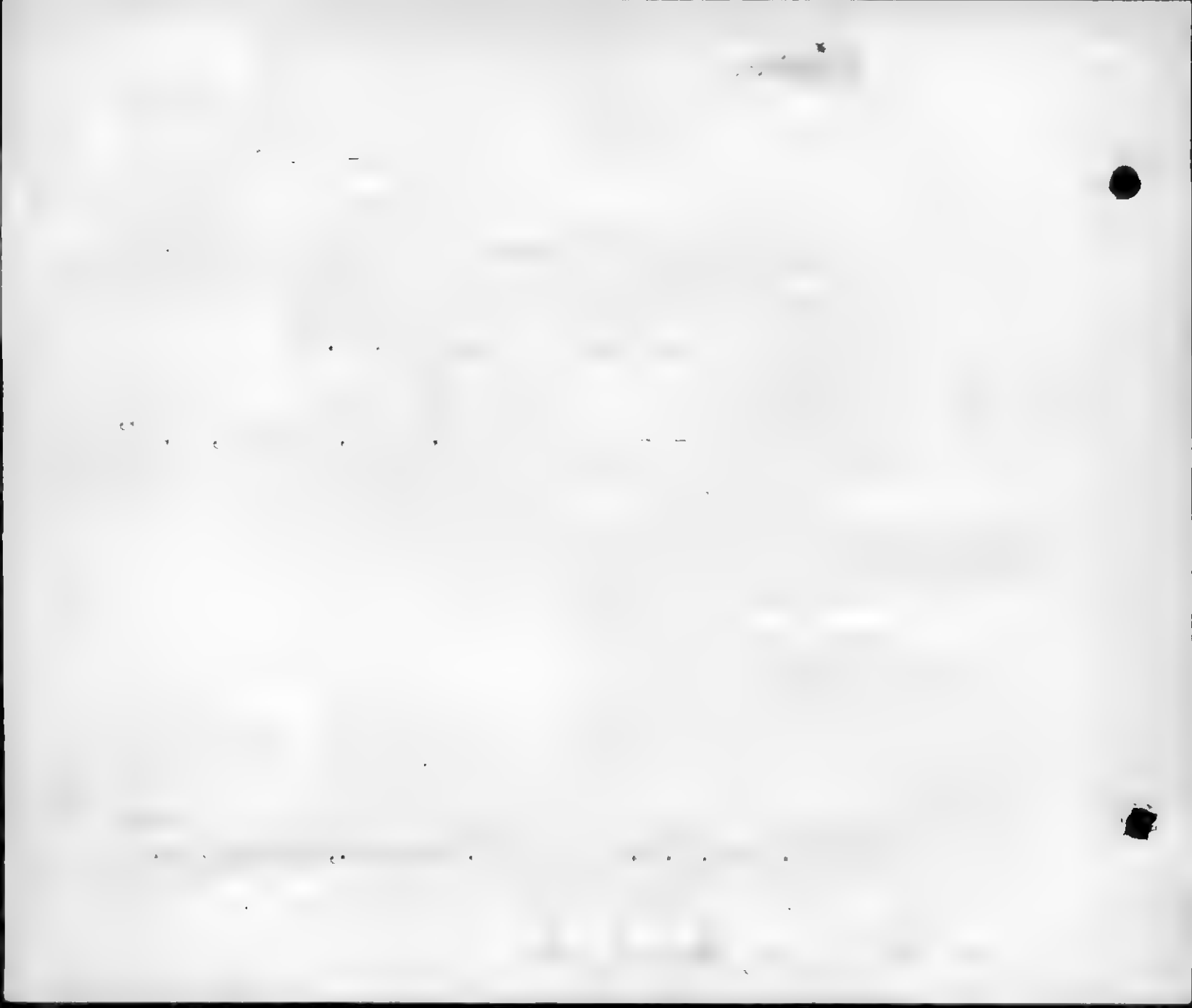
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13850

13860

| | | | | | | | |
|---|----------------------------------|---|---------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b 2 Weeks | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle AUGUSTUS Last MASSER | | | | 4. DATE OF DEATH Month December 12, Day 19 Year 60 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4 Aug 1876 | 9. AGE (In years last birthday) yrs 84 | IF UNDER 1 YEAR Months 84 Days 0 Hours 0 Min. 0 | IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm Owner | | 11. BIRTHPLACE (State or foreign country) Shookstown, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Frederick Masser | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Klipp | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-10-5278 | | 17. INFORMANT 323 Braddock Ave., Frederick W. Masser, Frederick, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.5 Congestive heart failure DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) 10 yrs + | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour 0 m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/8 19 60 , to 12/12 19 60 , that (I) (we) last saw the deceased alive on 12/12 19 60 , and that death occurred at 6:15 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Henry V. Chase | | | | 22b. DATE SIGNED 14 Dec 1960 | | | |
| 22c. PHYSICIAN'S NAME (Type) Henry V. Chase, M. D. | | | | 22d. ADDRESS 4 E. Church St., Frederick, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-15-60 | | 23c. NAME OF CEMETERY OR CREMATORY Rocky Springs Cemetery | | 23d. LOCATION (City, town, or county) (State) Frederick County Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. K. Etchison & Son, Frederick, Md. | | | | 25a. REC'D BY REGISTRAR DATE DEC 15 '60 | | 25b. REGISTRAR'S SIGNATURE Charles E. Thrash | |

1
CP

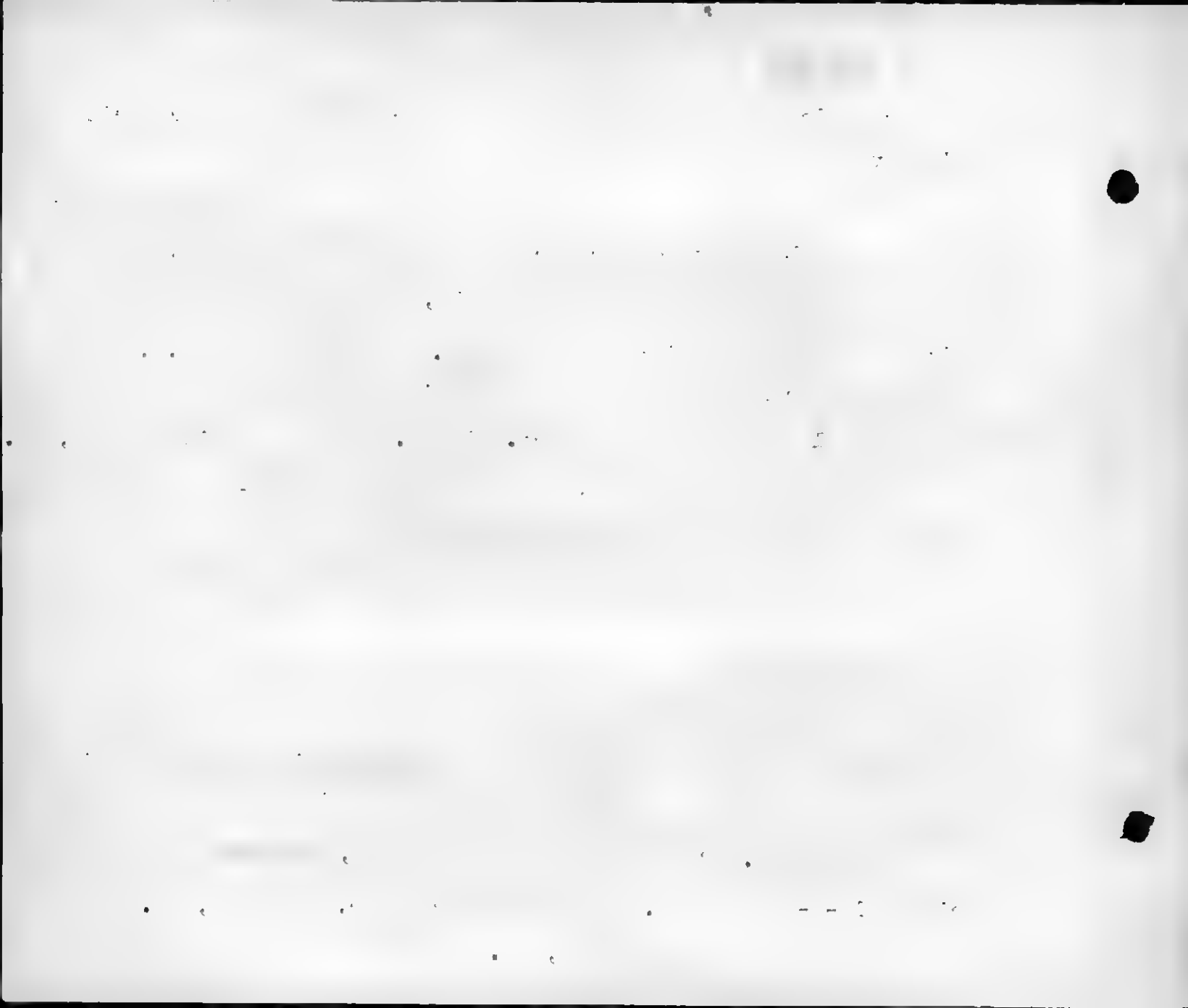


1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

13851

13891

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sabillasville | | c. LENGTH OF STAY IN 1b 20 yr | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Osba Middle Grover Last McAfee | | 4. DATE OF DEATH Month December Day 5 Year 19 60 | |
| 5. SEX male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 11, 1893 |
| 9. AGE (In years last birthday) 67 yrs | | IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67 | IF UNDER 24 HRS Months 67 Days 67 Hours 67 Min. 67 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY On farms | 11. BIRTHPLACE (State or foreign country) Md. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME Jefferson McAfee | |
| 14. MOTHER'S MAIDEN NAME Annie Duncan | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WWI | |
| 16. SOCIAL SECURITY NO No | | 17. INFORMANT Address Mrs. Alta W. McAfee Sabillasville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart disease Arteriosclerotic type 765X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pulmonary Emphysema DUE TO (c) Mustard gas poisoning - bronchial tubes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no | | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 30 yrs. 4 2 yrs. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) no | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 1958 to Dec. 5, 1960 that (I) last saw the deceased alive on Nov. 5, 1960 , and that death occurred at 4:30 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE James K. Gray | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) James K. Gray | | 22d. ADDRESS Thurmont, Maryland | |
| 23a. BURIAL CREMATION, DATE THEREOF REMOVAL (Specify) Burial 12-8-60 | | 23b. NAME OF CEMETERY OR CREMATORY Mt. Bethel Cemetery | |
| 23c. LOCATION (City, town, or county) (State) nr. Garfield, Md. | | 23d. REGISTRAR'S SIGNATURE | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Brieger | | 25a. REC'D BY REGISTRAR DATE DEC 9 '60 | |
| 25b. REGISTRAR'S SIGNATURE William S. Hume | | 25c. REGISTRAR'S SIGNATURE | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13852

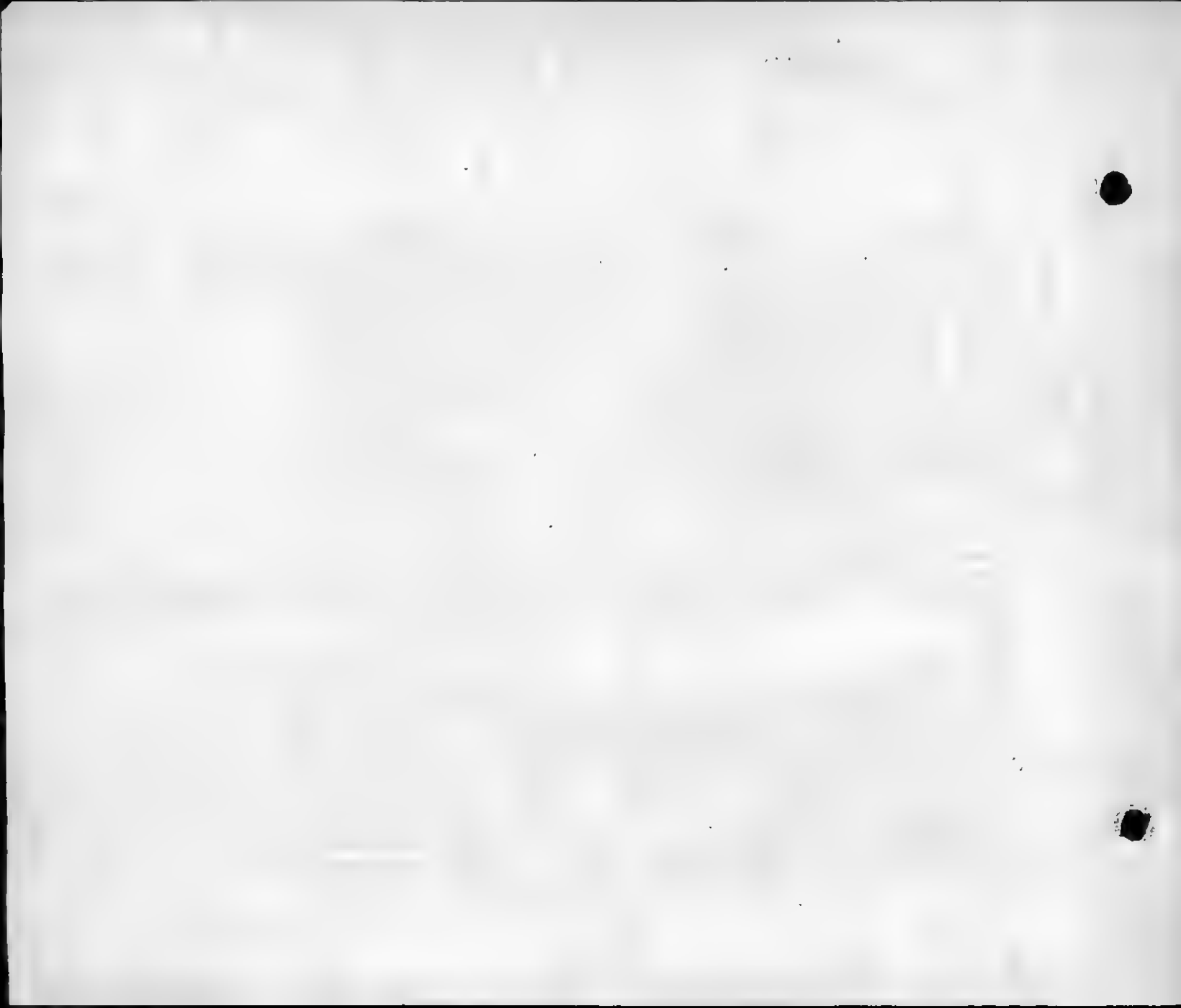
FOR STATE
HEALTH DEPT.

13892

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg RD 3</u> | | c. LENGTH OF STAY IN 1b <u>7 years</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS <u>Emmitsburg RD 3</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Charles Luther McClain</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 26 1908</u> |
| 9. AGE (In years last birthday) <u>51</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | 11. IF UNDER 24 HRS Hours <u> </u> Min <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Motor Express</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Fairfield #1 Penna</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Clarence M. McClain</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Riley</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes Army 24.12.21-12.24.42</u> | | 16. SOCIAL SECURITY NO <u>214-09-2995</u> | |
| 17. INFORMANT <u>Mrs Dorothy McClain</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) stating the underlying cause last. (c) <u> </u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>B. D. Thomas</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>B. D. Thomas, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>12/16/60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Fairfield</u> | | 22d. LOCATION (City, town, or county) (State) <u>Fairfield Penna.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Hove</u> | | 24a. REC'D BY REGISTRAR <u> </u> DATE <u>DEC 19 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hove</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

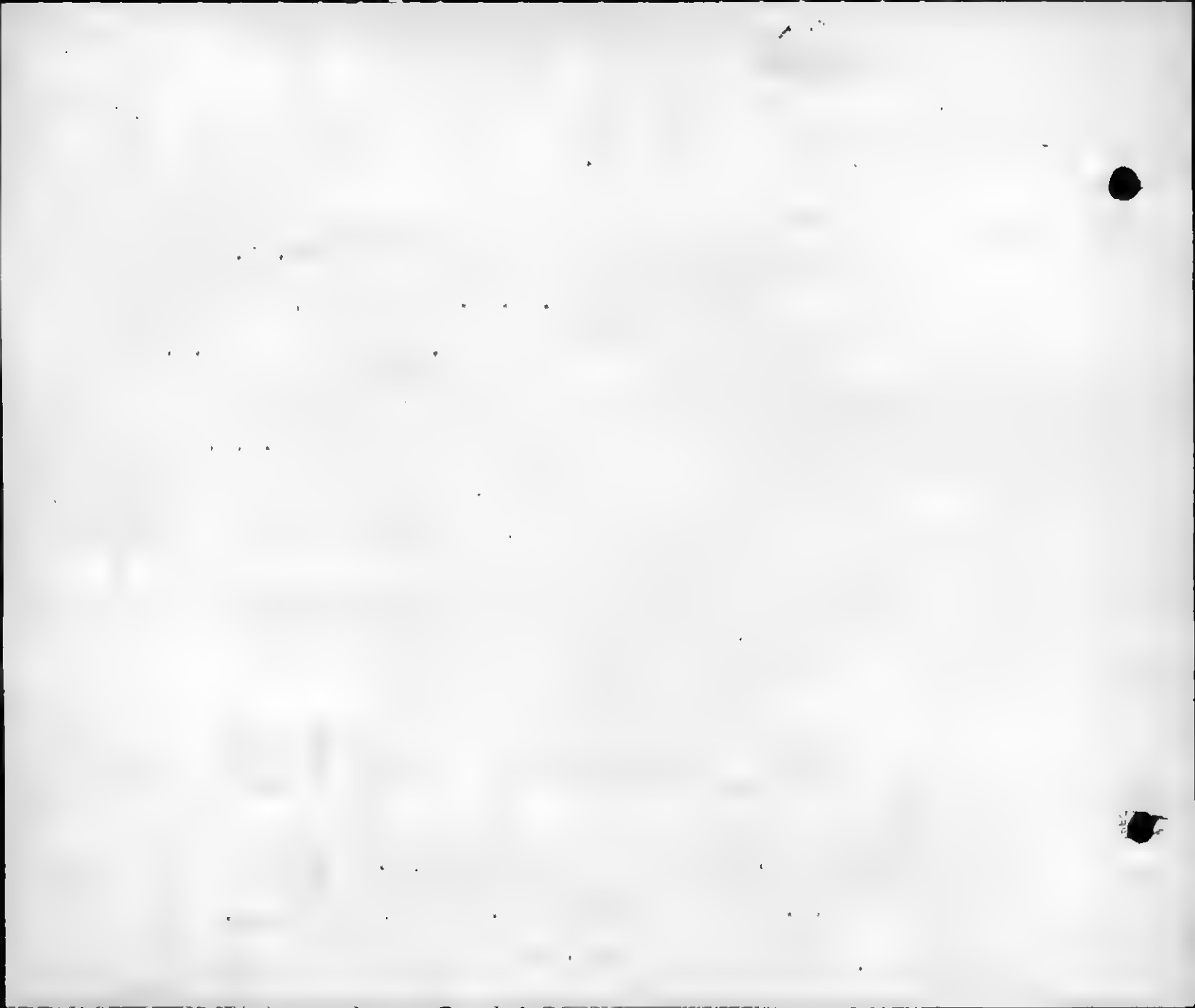


TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | |
|---|--|---|---|--|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD b. COUNTY Frederick | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont Rural | | | c. LENGTH OF STAY IN 1b 40 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont Rural | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home | | | | | e. STREET ADDRESS 1 | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) HATTIE First JOSAPHINE Middle MILLER Last | | | | | 4. DATE OF DEATH Dec. 31. 1960 Month 19 Day Year | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 5. 1885 | | 9. AGE (In years last birthday) 75 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Mass. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | | |
| 13. FATHER'S NAME Thomas Obrein | | | | | 14. MOTHER'S MAIDEN NAME Harriette MESSER | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Henry Miller Thurmont. R.D. 2 MD Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis - DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) 22X DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 hours 2 yrs. | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) None | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 26 - 1960, to Dec. 31, 1960, that (I) (we) last saw the deceased alive on Dec. 31 - 1960, and that death occurred at 10 P.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE James K. Gray | | | | | 22b. DATE Dec. 31, 1960 | | 22c. PHYSICIAN'S NAME (Type) James K. Gray | | |
| 22d. ADDRESS Thurmont. MD | | | | | 22e. DATE SIGNED Dec. 31, 1960 | | 22f. SIGNATURE Arthur L. Kraus | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) Burial Jan. 3. 1961 | | 23b. DATE THEREOF Jan. 3. 1961 | | 23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cem. | | | 23d. LOCATION (City, town, or county) (State) Thurmont, Fredk. Co MD | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Crager | | | | | 25a. REC'D BY REGISTRAR JAN 4 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus | | |

13893

13853



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

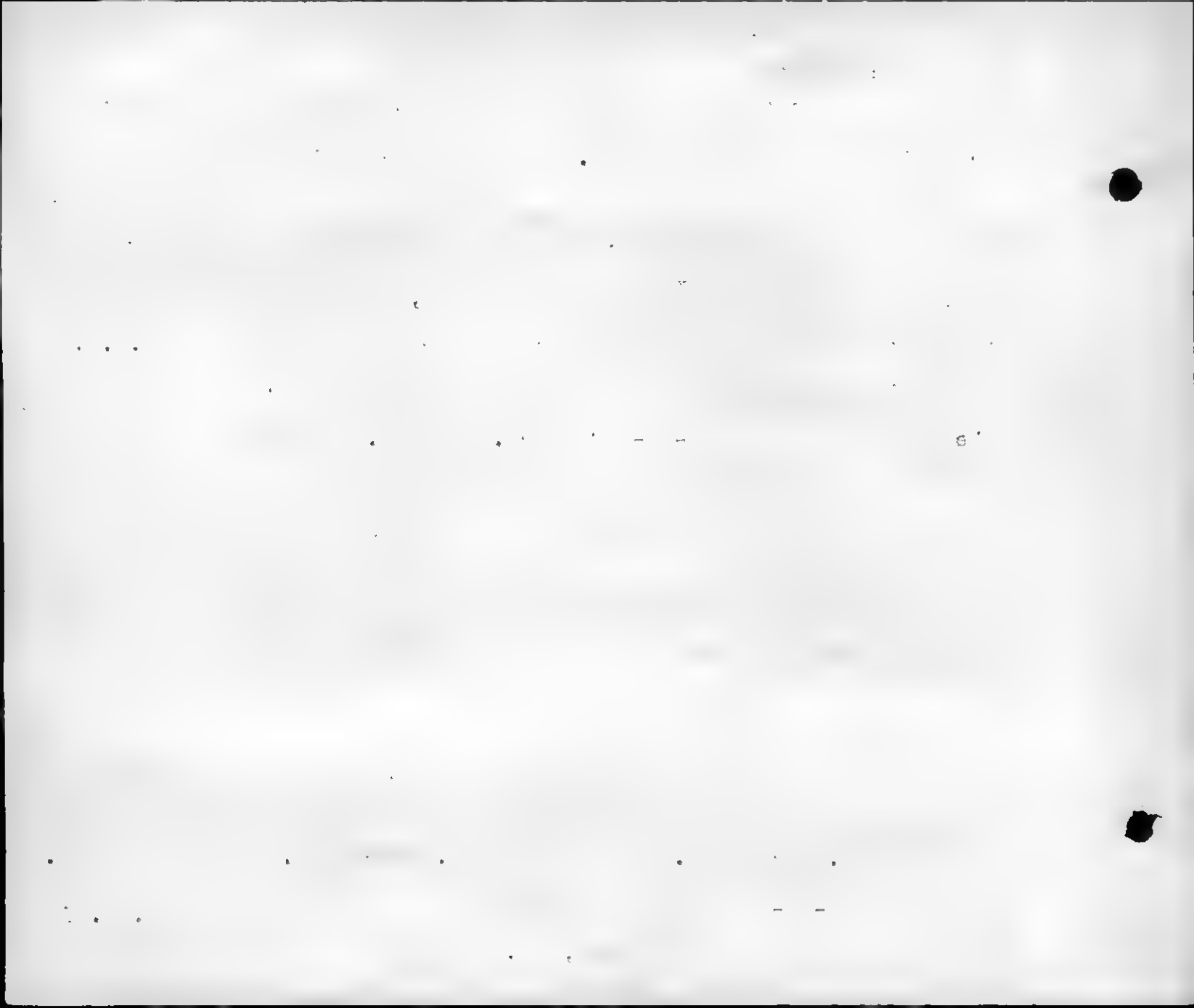
13854

13894

CERTIFICATE OF DEATH

Item 9 111m6277 1-21-60 et

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick rural | | c. LENGTH OF STAY IN lb 50 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) John Henry Morningstar | | 4. DATE OF DEATH December 15 19 60 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 27, 1896 |
| 9. AGE (In years, months, days, hours, minutes) MA 64 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor | | 10b. KIND OF BUSINESS OR INDUSTRY Own Business | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Morningstar | | 14. MOTHER'S MAIDEN NAME Lucy Steiner | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) Yes (If yes, give year or date of service) WWI | | 16. SOCIAL SECURITY NO. 233-05-4598 | |
| 17. INFORMANT Mrs. Helen T. Morningstar | | Address Frederick | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro VASCULAR ACCIDENT - 331X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchitis & emphysema | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/ 1960 to 12 1960 , that (II) (we) lost the deceased alive on 12/13 1960 , and that death occurred at 8 A.M. from the causes and on the date stated above | | | |
| 22a. SIGNATURE Richard C. Reynolds, | | 22b. ADDRESS 9 E. Church St. Frederick, Md. | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Richard C. Reynolds | | 22d. ADDRESS 9 E. Church St. Frederick, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-18-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Glade Cemetery | | 23d. LOCATION (City, town, or county) (State) Walkersville Fredk. Co. Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager | | 25. REC'D BY REGISTRAR DEC 20 '60 | |
| ADDRESS Thurmont, Md. | | 25b. REGISTRAR'S SIGNATURE John S. Thoma | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13874

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13855

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick 35 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B & O R.R. East bound hump | | d. STREET ADDRESS 110 East "A" Street | |
| 3. NAME OF DECEASED (Type or print) First Carlton Middle - Last New | | 4. DATE OF DEATH Month 12 Day 20 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-4-1918 |
| 9. AGE (in years last birthday) 42 yrs | | 10. IF UNDER 1 YEAR Months 12 Days 20 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman | | 10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R. Co | |
| 11. BIRTHPLACE (State or foreign country) Georgia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James New | | 14. MOTHER'S MAIDEN NAME Eula Bell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) World 11 | | 16. SOCIAL SECURITY NO. World 11 | |
| 17. INFORMANT Mrs. Frances New, Brunswick, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage caused by multiable fractures 800X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) while brakin freight car on R.R. B & O - fell under the car | |
| 20c. TIME OF INJURY Month, Day, Year 7:20 Hour 7:20 p. m. 12/22 1960 | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B & O RR yard | 20f. (City or town) (County) (State) Brunswick Fred. Md. |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE B. O. Thomas M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) B. O. Thomas | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-23-1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY saint Marks | | 22d. LOCATION (City, town, or county) (State) Petersville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. H. E. E. Brunswick, Maryland | | 24a. REC'D BY REGISTRAR DEC 27 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hines | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Bureau of Health. If its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

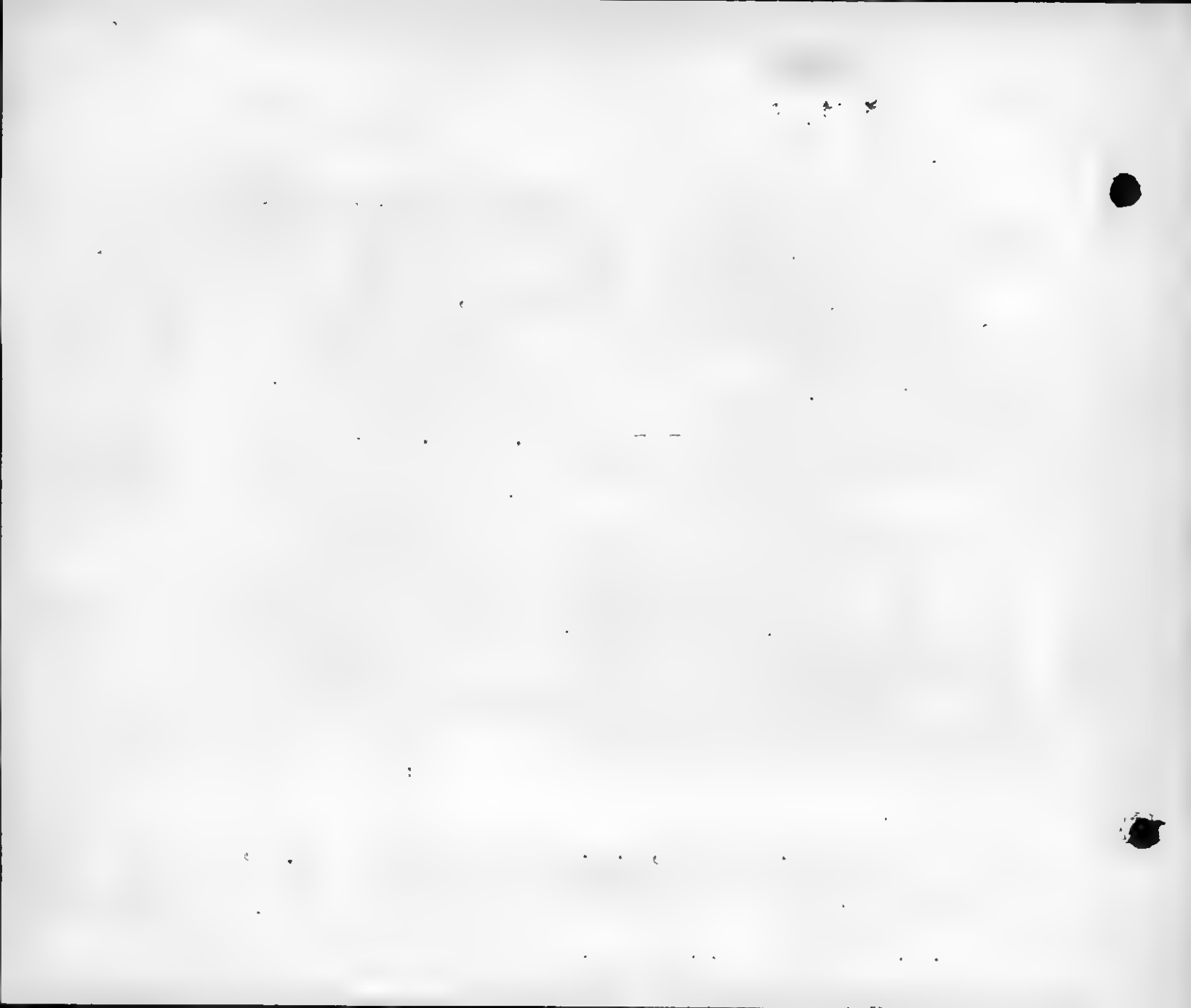


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be read by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
ISM 9/59

1
13861
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13856
CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b Years | |
| d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION 13 East Ninth Street | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last NULL | | 4. DATE OF DEATH Month December Day 29 , Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 11, 1891 |
| 9. AGE (In years last birthday) 69 yrs | | 10. IF UNDER 1 YEAR: Months 6 Days 1 Hours 1 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auctioneer | | 10b. KIND OF BUSINESS OR INDUSTRY Same | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William C. Null | | 14. MOTHER'S MAIDEN NAME Frances Cutsail | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 705-10-0008 | |
| 17. INFORMANT Mrs. Luma A. Null-Same as Item #2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis with (c) 1445. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recurrent divisional ulcer INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 14 years | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 8/19 to 12/29 , 19 60 that (I) (we) last saw the deceased alive on 12/7 , 19 60 , and that death occurred at 7:30P , from the causes and on the date stated above | | | |
| 22a. SIGNATURE L. R. Schoolman M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE 12/31/60 | | | |
| 22c. PHYSICIAN'S NAME (Type) Louis R. Schoolman, M. D. 22d. ADDRESS 816 Toll House Ave., Frederick, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 1/2/1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 25a. REC'D BY REGISTRAR JAN 4 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

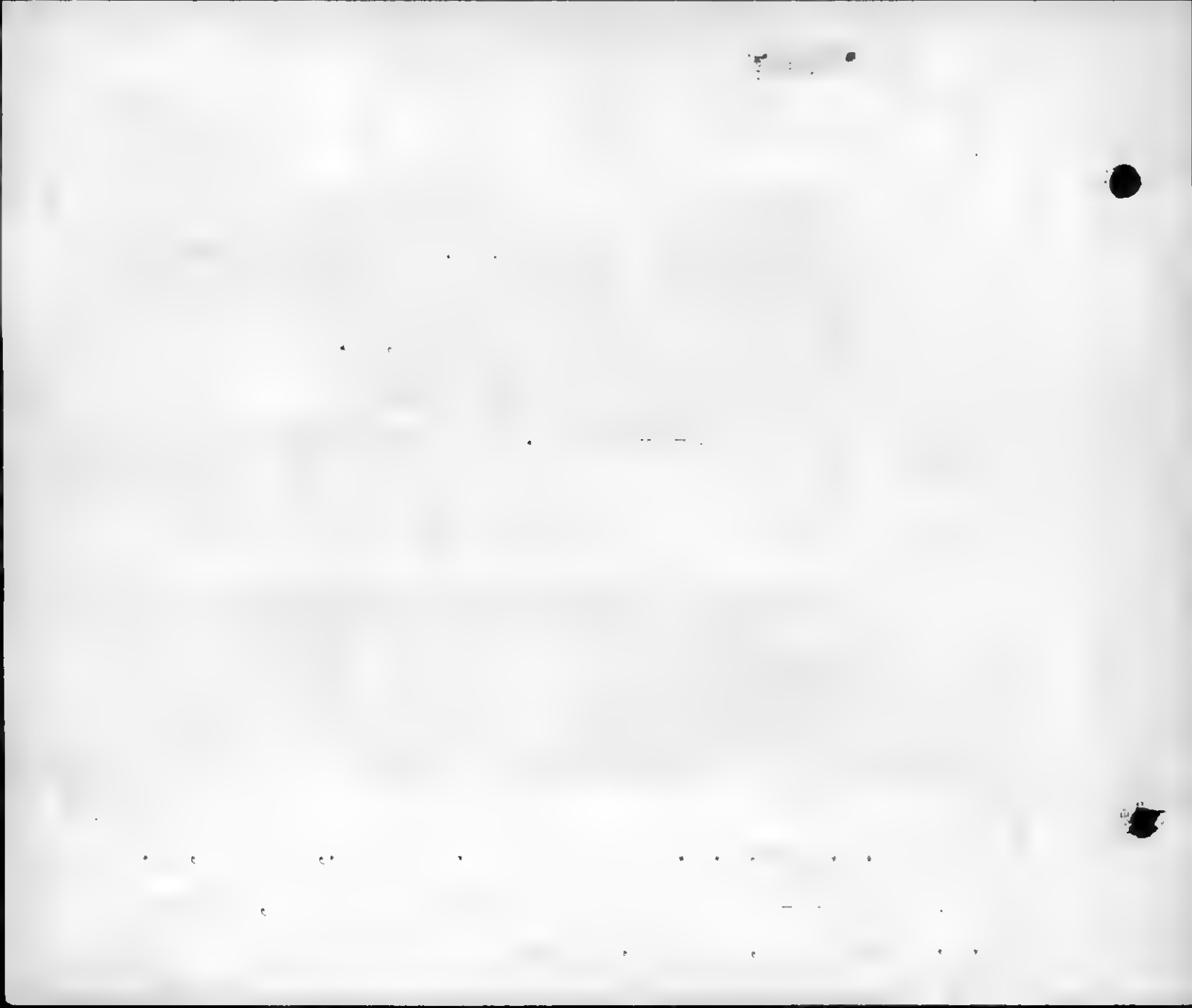
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13862

CERTIFICATE OF DEATH

13857

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived If institut an Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. LENGTH OF STAY IN 1b Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 606 Charles Street | | | | e. STREET ADDRESS 606 Charles Street | | | |
| f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3 NAME OF DECEASED (Type or print) First MELVIN Middle ROY Last NUSZ, SR. | | | | 4 DATE OF DEATH Month December Day 8, Year 1960 | | | |
| 5 SEX Male | | 6 COLOR OR RACE White | | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 13 March 1904 | |
| 9 AGE (In years last birthday) 56 yrs | | 10. UNDER 1 YEAR Months 56 Days 56 Hours 56 Min. | | 11. UNDER 24 HRS Months 56 Days 56 Hours 56 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man | | | | 10b. KIND OF BUSINESS OR INDUSTRY Oil Company | | 11. BIRTHPLACE (State or foreign country) Frederick, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Elmer Nusz | | | | 14. MOTHER'S MAIDEN NAME Clara Smith | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-10-2689 | | 17. INFORMANT Mrs. Bertha Nusz (Same as item #1) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Hypertension | | | | INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 24 hrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1930 to Dec 8 1960, that (I) (we) last saw the deceased alive on Dec 8 1960, and that death occurred at 7:30 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE H. F. Kline | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED 10 Dec 1960 | |
| 22c. PHYSICIAN'S NAME (Type) H. F. Kline, M. D. | | | | 22d. ADDRESS 7 N. Market St., Frederick, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-11-60 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | ADDRESS M. R. Etchison & Son, Frederick, Maryland | | 25a. REC'D BY REGISTRAR DATE DEC 12 '60 | |
| 25b. REGISTRAR'S SIGNATURE W. S. Kline | | | | | | | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

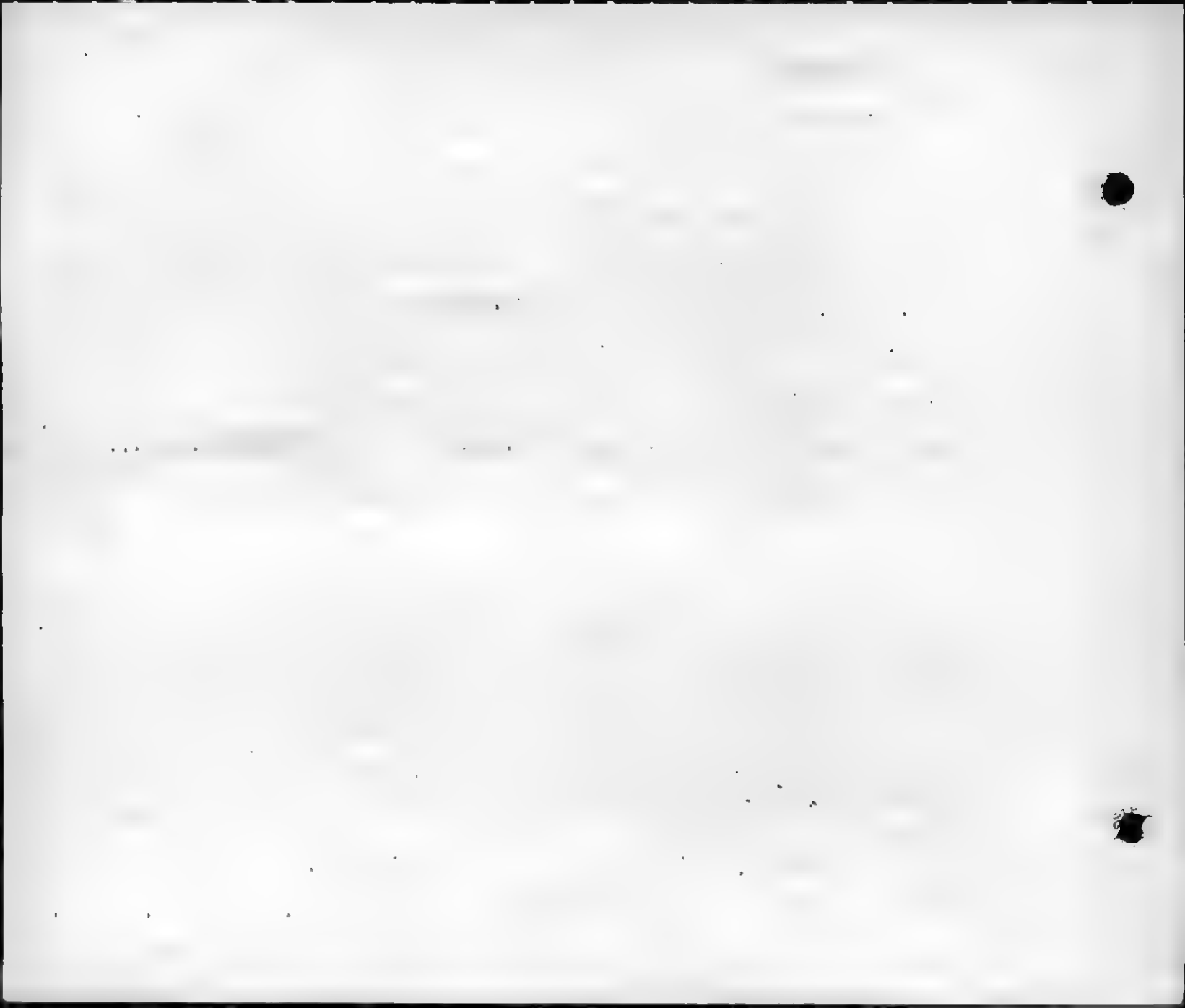
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13858

13895

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen | | | | c. LENGTH OF STAY IN 1b 5 weeks | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital | | | | d. STREET ADDRESS 320 Waverly Terrace | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Walter Middle William Last Orndorff | | | | 4. DATE OF DEATH Month December Day 21 Year 1960 | | | |
| 5. SEX M. | | 6. COLOR OR RACE W. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 22, 1921 | |
| 9. AGE (In years last birthday) 39 yrs | | F. UNDER 1 YEAR (If under 24 hrs) | | Months 39 Days 39 Hours 39 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) roofer | | | | 10b. KIND OF BUSINESS OR INDUSTRY roofing | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME John Orndorff | | | | 14. MOTHER'S MAIDEN NAME Flossie Welsh | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 220-10-0655 | | 17. INFORMANT Mrs. Flossie Hudson | | Address 351 Balto. Ave., Md. Cumberland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral pulmonary tuberculosis | | | | | | | |
| DOX DUE TO | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO | | | | | | | |
| (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month. Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11-15-60 19 to 12-21-60 19, that (I) (we) last saw the deceased alive on 12-21-60 19, and that death occurred on 9.45 pm from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Michael G. Zavis | | | | M D ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 12-21-60 | |
| 22c. PHYSICIAN'S NAME (Type) Michael G. Zavis | | | | 22d. ADDRESS Cullen, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/26/60 | | 23c. NAME OF CEMETERY OR CREMATORY Bald Hill Cemetery | | 23d. LOCATION (City, town, or county) (State) Hazen Rd. Bedford Co. Penna. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Angus E. ... | | | | ADDRESS Thermon Md | | 25a. REC'D BY REGISTRAR DATE DEC 27 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Arthur S. ... | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13896

CERTIFICATE OF DEATH

Reg. Dist. No.

13859

| | | | | | | | |
|--|------------------------------|--|---------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH o COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>FREDERICK</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Point of Rocks</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ward 200 WRGH</u> | | | | d. STREET ADDRESS <u>1</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Terri Lee Pearl</u> | | | | 4. DATE OF DEATH Month Day Year <u>December 19 1960</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>26 June 60</u> | 9. AGE (In years last birthday) yrs. <u>6</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Eugene F. Pearl</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY M. MCKELL</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bacterial Meningitis</u> <u>3403</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemophilus influenza</u> DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Purulent Otitis Media</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>17 Dec.</u> 19 <u>60</u> , to <u>19 Dec.</u> 19 <u>60</u> , that I last saw the deceased alive on <u>19 Dec.</u> 19 <u>60</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>James W. Bass</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>19 Dec 60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>James W. Bass</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>12-22-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u> | | 22d. LOCATION (City, town, or county) (State) <u>JEFFERSON MARYLAND</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Lee Fuchs</u> ADDRESS <u>BRUNSWICK, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>DEC 27 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur P. H.</u> | |



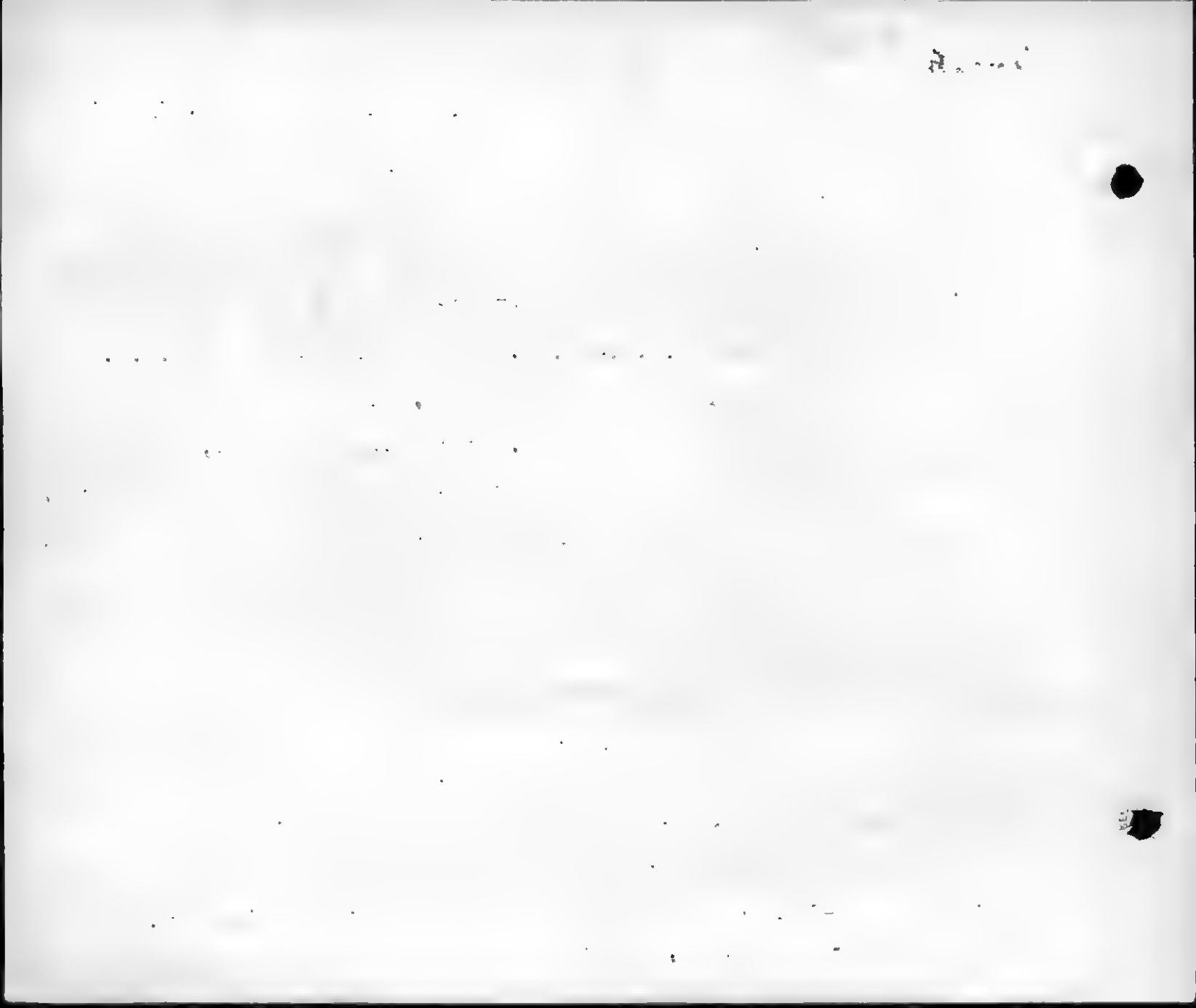
13875 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

Reg. Dist. No. 13860

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick c. LENGTH OF STAY IN Tb | | 2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick d. STREET ADDRESS 7 North Maple Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Charles Middle William Last Rau | | 4. DATE OF DEATH Month 12 Day 31 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-22-1894 |
| 9. AGE (In years last birthday) 66 yrs. | | 10. IF UNDER 1 YEAR Months 6 Days 10 Hours 10 Min. | 11. IF UNDER 24 HRS Months 6 Days 10 Hours 10 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Retired Yard Foreman B. & O. R. R. Co.) | | 10b. KIND OF BUSINESS OR INDUSTRY West Virginia | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William O. Rau | | 14. MOTHER'S MAIDEN NAME Mary Agnes Conway | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. Informant Address Mrs. Marie Rau, Brunswick, Maryland | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure DUE TO (c) Coronary Insufficiency | | INTERVAL BETWEEN ONSET AND DEATH 10 min. 3 min. 1 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 28, 1960 to Dec. 31, 1960 that I last saw the deceased alive on Dec. 31, 1960 , and that death occurred at 9:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 S. Maryland Ave. Brunswick, Md. DATE SIGNED 1-3-61 | | | |
| ACTUAL SIGNATURE C. T. Byron Rao, M.D. | | PHYSICIAN'S NAME (Type) C. T. Byron Rao, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-3-1961 | |
| 22c. NAME OF CEMETERY OR CREMATORY Saint Peters | | 22d. LOCATION (City, town, or county) (State) Harpers Ferry W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Brunswick, Maryland | | 24a. REC'D BY REGISTRAR JAN 5 '61 | |
| 24b. REGISTRAR'S SIGNATURE Charles E. Kenna | | | |

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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13863
CERTIFICATE OF DEATH

13861

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b 11 Years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 215 East Fifth Street | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 215 East Fifth Street | | e. STREET ADDRESS 215 East Fifth Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First DANIEL Middle W. Last RENNER | | 4. DATE OF DEATH Month December Day 8 , Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 25 Dec 1861 |
| 9. AGE (In years last birthday) 98 yrs | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm Owner | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Elias Renner | | 14. MOTHER'S MAIDEN NAME Catherine Dusing | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Franklin C. McCanner (Same as item #1) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Pneumia Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular disease DUE TO 5 days (c) 5 yrs | | INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month. Day. Year Hour 0 a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1945 to Dec 8, 1961 , that (I) (we) last saw the deceased alive on Dec 7, 1960 , and that death occurred at 11 A M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE B. O. Thomas | | 22b. DATE SIGNED 10 Dec 1960 | |
| 22c. PHYSICIAN'S NAME (Type) B. O. Thomas, M. D. | | 22d. ADDRESS 228 N. Market St., Frederick, Md. | |
| 23a. BURIAL, CREMATON, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-10-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 23d. LOCATION (City, town or county) (State) Frederick, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 25a. REC'D BY REGISTRAR DATE DEC 12 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

13864

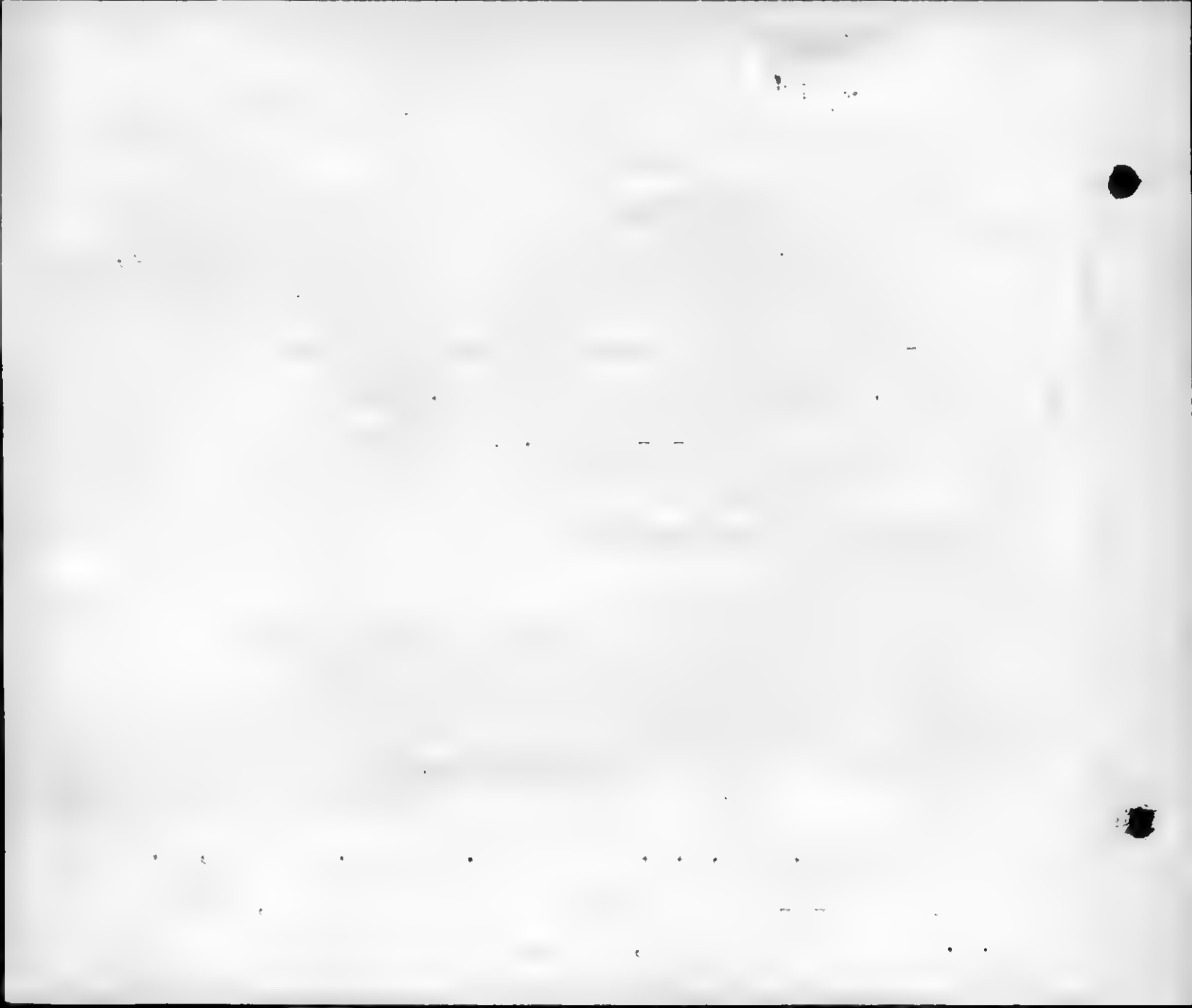
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13862

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | | |
| c. LENGTH OF STAY IN 1b Life | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DOA Frederick Memorial Hospital | | | | d. STREET ADDRESS 505 Fleming Avenue | | | |
| | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First HARRY Middle WALTER Last RIDGELY | | | | 4. DATE OF DEATH Month December Day 18 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 28 June 1890 | |
| 9. AGE (In years and birthday) 70 yrs | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Painter | | | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) Frederick, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Charles G. Ridgely | | | | 14. MOTHER'S MAIDEN NAME Ellen M. Stull | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 219-12-0625 | | 17. INFORMANT Address Mrs. Margaret Ridgely (Same as item #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary occlusion +20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis of coronary vessels DUE TO (c) 10 yrs | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 min |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 1954 to Dec. 18, 1960 , that (I) (we) last saw the deceased alive on Dec 17, 1960 , and that death occurred at 8:30 P. M, from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Henry V. Chase M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 20 Dec 1960 | |
| 22c. PHYSICIAN'S NAME (Type) Henry V. Chase, M. D. | | | | 22d. ADDRESS 4 D. Church St., Frederick, Md. | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-21-60 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 25a. REC'D BY REGISTRAR DEC 23 '60 | | 25b. REGISTRAR'S SIGNATURE <i>Sealing & Signing</i> | |

M

I



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13863

13863

| | | | | | | | |
|---|----------------------------------|---|-------------------------------------|--|--------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. AIRY | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL | | | | d. STREET ADDRESS Hill street | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MATTIE W. RUNKLES | | | | 4. DATE OF DEATH Month Day Year DECEMBER 24 1960 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-3-1894 | 9. AGE (In years last birthday) 86 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) MARYLAND | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Henry Wilson | | | | 14. MOTHER'S MAIDEN NAME Martha L. Watkins | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Address Henry P. Runkles. Mt. Airy, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastro-intestinal Hemorrhage DUE TO Cause Undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) 3 days | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) Arteriosclerotic Cardio-vascular Disease | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) — | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-21- 1960 to 12-24- 1960, that (I) (we) last saw the deceased alive on 12-24- 1960, and that death occurred at 2:45 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE A. A. Pearre | | | | 22b. DATE SIGNED 12/24/60 | | | |
| 22c. PHYSICIAN'S NAME (Type) A. A. PEARRE | | | | 22d. ADDRESS Frederick, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 12-26-1960 | | 23c. NAME OF CEMETERY OR CREMATORY Prospect | | 23d. LOCATION (City, town, or county) (State) Frederick Co., Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, | | | | ADDRESS Winfield, Md. | | 25a. REC'D BY REGISTRAR DATE 12-24-60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas | | | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13864

13897

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | | | |
|--|------------------|---|------------------|--|---------------------------------|--|-----------------|
| 1. PLACE OF DEATH a. COUNTY <u>Rock</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>2</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leesville Md.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leesville</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas</u> <u>William</u> <u>1</u> | | | | 4. DATE OF DEATH Month Day Year <u>19</u> <u>11</u> <u>19</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY | | | | 13. FATHER'S NAME | | | |
| 14. MOTHER'S MAIDEN NAME | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>None</u> DUE TO Underlying cause last (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>B. O. Thomas</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) | |
| <u>Burial</u> | | <u>10.30. 1900</u> | | <u>Pipe Creek</u> | | <u>Near Uniontown</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | | | 24a. REC'D BY REGISTRAR | | | |
| <u>Raymond K. Wright</u> | | | | DATE <u>11.1.19</u> | | | |
| ADDRESS <u>Union Bridge, Md.</u> | | | | 24b. REGISTRAR'S SIGNATURE | | | |
| | | | | <u>Raymond K. Wright</u> | | | |

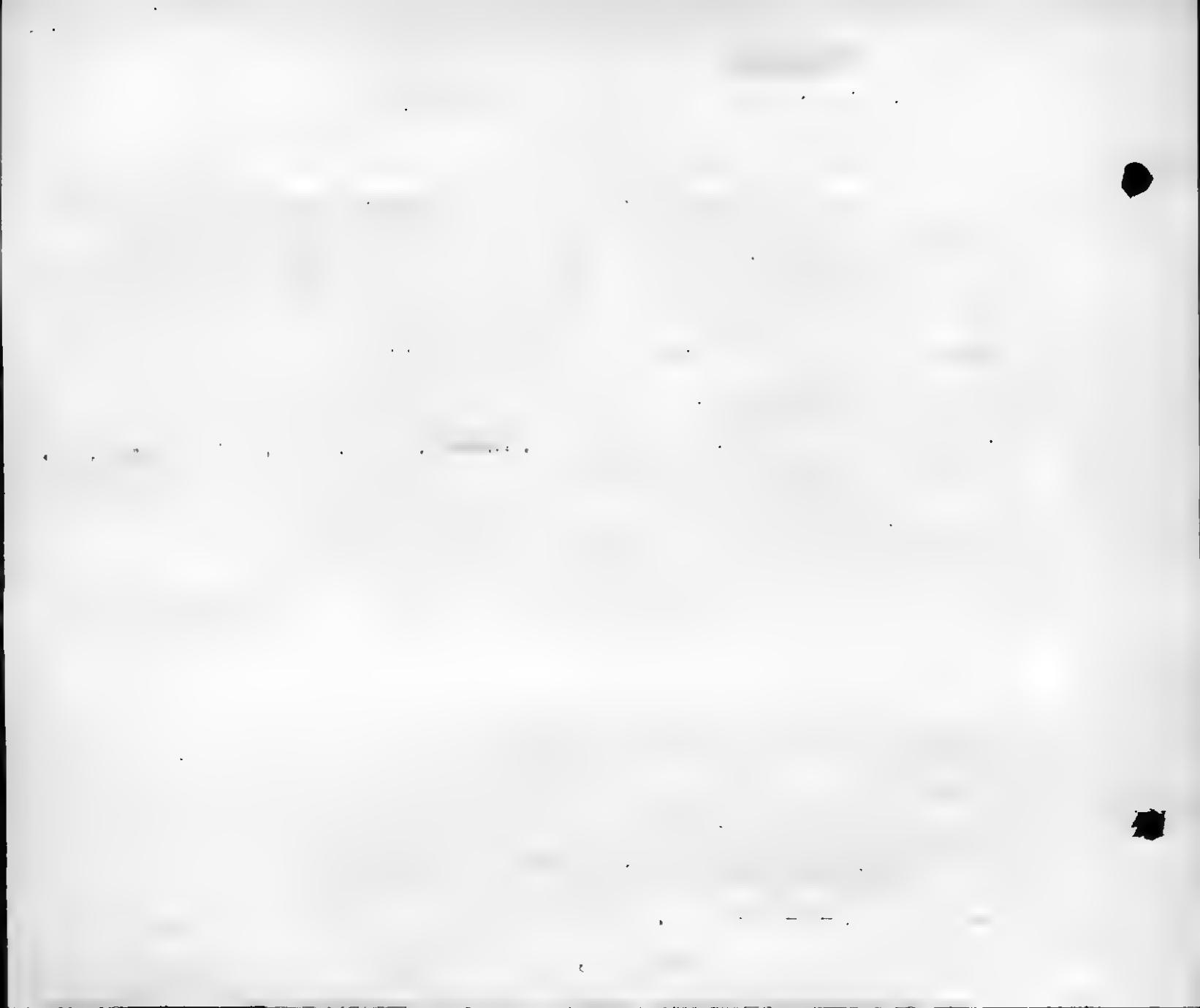
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13866
CERTIFICATE OF DEATH

13865

| | | | | | | | |
|--|----------------------------------|---|--------------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK | | | | c. LENGTH OF STAY IN 1b FREDERICK Route # 3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL | | | | d. STREET ADDRESS Frederick Route # 3 | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CLINTON M SCHWARTZ | | | | 4. DATE OF DEATH Month Day Year DECEMBER 25, 1960 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-13-1890 | 9. AGE (In years last birthday) 70 yrs | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME SAMUEL SCHWARTZ | | | | 14. MOTHER'S MAIDEN NAME ALICE BOYER Peters | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 220-34-1122 | | 17. INFORMANT Name Address Bulah Mrs. Walter V. Schwartz Rt. # 3 Frederick, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 9 to 12-25 , 1960, that (I) (we) last saw the deceased alive on 12-25 , 1960, and that death occurred at 6:15 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE B. O. Thomas M.D. | | | | 22b. ADDRESS Frederick, Md. | | 22c. DATE SIGNED DEC 25, 1960 | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-28-1960 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Gilkey | | | | 25a. REC'D BY REGISTRAR DEC 29 '60 | | 25b. REGISTRAR'S SIGNATURE Catherine L. Thomas | |



1
FOR STATE
HEALTH DEPT.

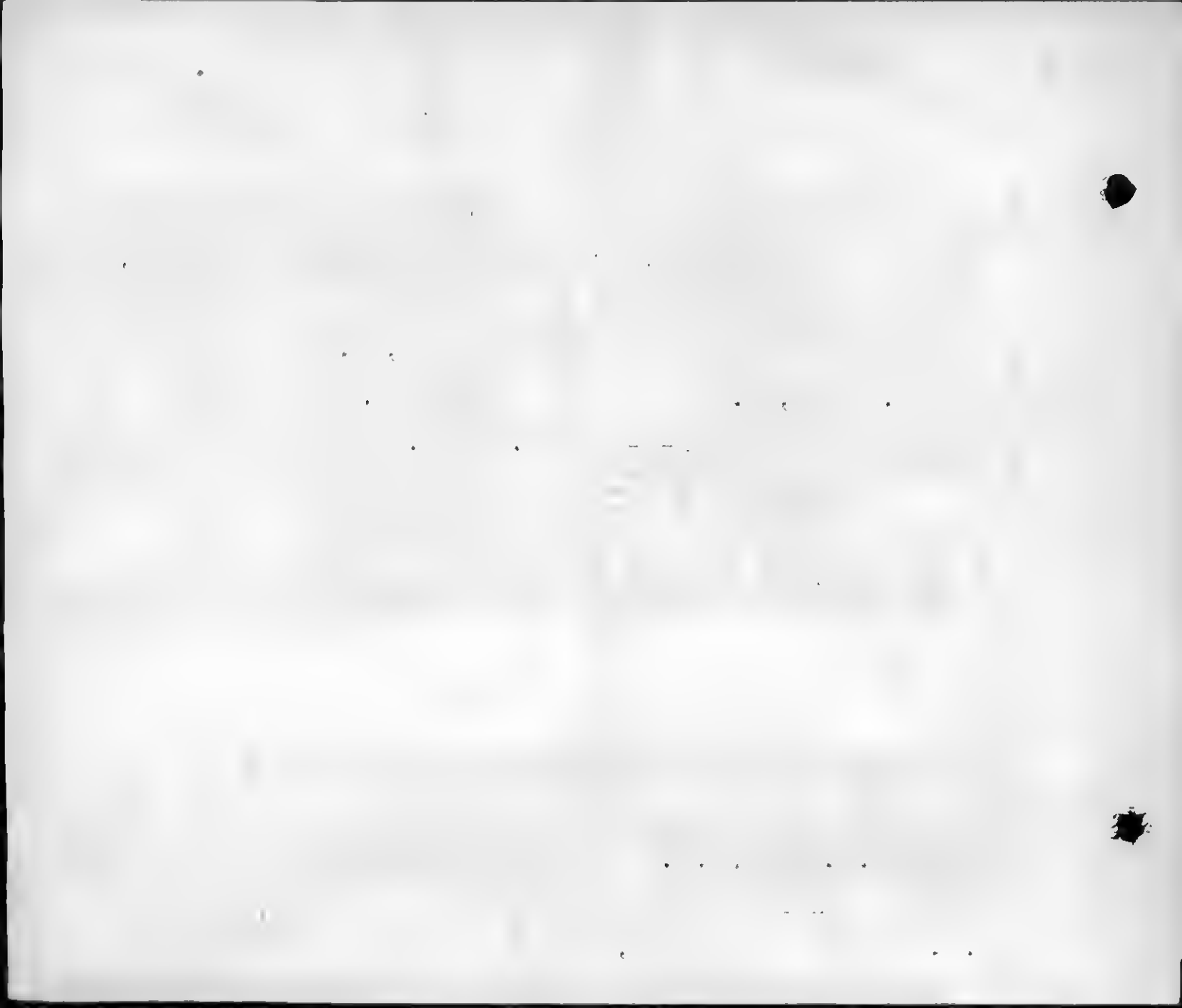
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13867 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13866

Reg. Dist. No

| | | | |
|---|----------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 207 East Second Street | | d. STREET ADDRESS 207 East Second Street | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CHARLES AUSTIN SHERALD | | 4. DATE OF DEATH Month Day Year December 12, 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 30 Aug 1919 |
| 9. AGE (in years last birthday) 41 yrs | | 10. UNDER 1 YEAR Months Days | 11. UNDER 24 HRS Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman | | 10b. KIND OF BUSINESS OR INDUSTRY Optical Company | |
| 11. BIRTHPLACE (State or foreign country) Frederick, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Allen F. Sherald, Sr. | | 14. MOTHER'S MAIDEN NAME Elizabeth M. Sullivan | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII | | 16. SOCIAL SECURITY NO 212-14-7107 | |
| 17. INFORMANT Mrs. Betty L. Sherald | | Address (Same as item #1) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion | | | |
| 420-1 DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE B. O. Thomas | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) B. O. Thomas, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-15-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | 24a. REC'D BY REGISTRAR DEC 15 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Bureau of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 13867

13898

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick R 7</u> | | | | c. LENGTH OF STAY IN 1b <u>367 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Co. Chronic Hosp.</u> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Moukrona</u> | | | |
| f. STREET ADDRESS | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>GEORGE WILLIAM SHOEMAKER</u> | | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>1960</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 19 1868</u> | 9. AGE (In years last birthday) <u>92</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Freight Transfer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Samuel Shoemaker</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Ellen Orrison</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>219-14-9934A</u> | | 17. INFORMANT <u>Mr. Ernest Shoemaker, Walkersville RI, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> | | | | 2 yrs. | | | |
| DUE TO (b) <u>122.1</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | (c) <u>Arterio Sclerosis</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from <u>Dec 19 1960</u> to <u>Dec 28 1960</u> , that I last saw the deceased alive on <u>Dec 27 1960</u> , and that death occurred at <u>7:55 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>H.F. Kline</u> M.D. | | | | <u>7711 North St Frederick Md</u> <u>Dec 29 1960</u> | | | |
| PHYSICIAN'S NAME (Type) <u>H.F. KLINE M.D.</u> | | | | <u>Frederick Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>12/31/60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u> | 22d. LOCATION (City, town, or county) <u>Point of Rocks</u> | (State) <u>Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H.C. Barton, Walkersville, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>JAN 3 '61</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. H.</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13868

13868

| | | | | | | | |
|--|---------------------------|--|-------------------------------------|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH o COUNTY <u>Frederick</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | | | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Frederick-Rural RD#6</u> | | | |
| d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Frederick Memorial</u> | | | | d STREET ADDRESS <u>Linganore Road</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print) First <u>BARBARA</u> Middle <u>JEAN</u> Last <u>SMITH</u> | | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>9</u> Year <u>1960</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 6, 1960</u> | | 9. AGE (In years last birthday) yrs | IF UNDER 1 YEAR Months <u>3</u> Days | IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Ralph Lorraine Smith</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine Boyen</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16 SOCIAL SECURITY NO | | 17. INFORMANT <u>Mother</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: <u>776X</u> IMMEDIATE CAUSE (a) DUE TO | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) <u>Immaturity</u> | | | | | | | <u>3 dys</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from <u>6 Dec</u> 19 <u>60</u> to <u>9 Dec</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>8 Dec</u> 19 <u>60</u> , and that death occurred at <u>7:45 AM</u> from the causes and on the date stated above. | | | | | | | |
| 22a SIGNATURE <u>R L Guest</u> | | | | 22b DATE SIGNED | | 22c PHYSICIAN'S NAME (Type) <u>R. L. Guest, M. D.</u> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b DATE THEREOF <u>12-10-60</u> | | 23c NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u> | | 23d LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u> | |
| 24 FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u> | | | | 25a REC'D BY REGISTRAR <u>DEC 12 '60</u> | | 25b REGISTRAR'S SIGNATURE <u>Conner E. Kraus</u> | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corporate stamp. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13878

13869

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont | | c. LENGTH OF STAY IN 1b Lifetime | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont | |
| f. STREET ADDRESS Water Street | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Minia D. Middle Smith Last Smith | | 4. DATE OF DEATH Month Dec. Day 3 Year 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 12, 1874 |
| 9. AGE (In years, low birthday) 86 yrs | | 10. IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min 86 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Benjamin Firor | | 14. MOTHER'S MAIDEN NAME Amanda Lightner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO None | |
| 17. INFORMANT Lillian Smith | | Address Thurmont, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart disease - Arteriosclerotic Type 420.0 DUE TO Generalized arteriosclerosis - severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 years. (c) 2 years. | | INTERVAL BETWEEN ONSET AND DEATH 1 year 2 years. | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post-paralytic general enfeeblement | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) no | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 5, 1957 to Dec 3, 1960 that (I) (we) last saw the deceased alive on Nov. 30, 1960 and that death occurred at 8 p.m. from the causes and on the date stated above | | | |
| 22a. SIGNATURE James K. Gray | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) James K. Gray | | 22d. ADDRESS Thurmont, Maryland | |
| 23a. BURIAL CREMATION REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-6-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY United Brethern Cem. | | 23d. LOCAT ON (City, town, or county) (State) Thurmont, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Crager | | 25a. REC'D BY REGISTRAR DEC 8 '60 | |
| ADDRESS Thurmont, Maryland | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

13876

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13870

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i> | |
| b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <i>Brunswick</i> | c. LENGTH OF STAY IN 1b <i>Life</i> | c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <i>Brunswick</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Center Avenue</i> | | d. STREET ADDRESS <i>Center Avenue</i> | |
| 3. NAME OF DECEASED (Type or print) <i>John First William Spriggs</i> | | 4. DATE OF DEATH Month <i>12</i> Day <i>16</i> Year <i>1960</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>Col</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>4-7-1897</i> |
| 9. AGE (In years last birthday) <i>63</i> yrs | | IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> | IF UNDER 24 HRS Hours <i>0</i> Min <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>William Spriggs</i> | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Hunter</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO <i>—</i> | |
| 17. INFORMANT <i>Junie L. Spriggs</i> | | Address <i>Brunswick Md</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> a. m. <i>—</i> p. m. | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>B. O. Thomas</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <i>B. O. THOMAS</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. DATE OF REMOVAL (Specify) <i>12-19-60</i> | | 22b. NAME OF CEMETERY OR CREMATORY <i>Mountain</i> | |
| 22c. LOCATION (City, town, or county) (State) <i>Brunswick, Maryland</i> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>B. H. H. H.</i> | | ADDRESS <i>Brunswick Md</i> | |
| 24a. REC'D BY REGISTRAR DATE <i>DEC 23 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>—</i> | |

DATE SIGNED

12/16/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13871

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural | | c. LENGTH OF STAY IN 1b 25 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Calvin First David Middle Staub Last | | 4. DATE OF DEATH Dec. 2 Month 2 Day 19 Year 60 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 20, 1875 |
| 9. AGE (In years last birthday) 85 yrs | | 10. IF UNDER 1 YEAR Months 6 Days 2 Hours 0 Min | 11. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Farmers | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME David Staub | | 14. MOTHER'S MAIDEN NAME Cassandra Grushon | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Albert Staub | | Address Thurmont, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart disease, arteriosclerotic Type 420.0 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 yrs. (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 mos | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) None | |
| 20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 1 - 19 58 to Dec. 2 - 19 60 that (I) (we) last saw the deceased alive on Dec. 2 - 19 60 and that death occurred at 8 p.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE James K. Gray | | 22b. ADDRESS Thurmont, Md. | |
| 22c. PHYSICIAN'S NAME (Type) James K. Gray | | 22d. ADDRESS Thurmont, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-5-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Haugh's Cemetery | | 23d. LOCATION (City, town, or county) (State) near Ladiesburg, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Cragg | | 25a. REC'D BY REGISTRAR DEC 6 '60 | |
| ADDRESS Thurmont, Md. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13872

13869

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK, | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4 days / FREDERICK, | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL | | d. STREET ADDRESS 1 FREDERICK Maryland. | |
| 3. NAME OF DECEASED (Type or print) First ALEX Middle ROSCOE Last STROUP | | 4. DATE OF DEATH Month December Day 17 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Apr. 13, 1879 |
| 9. AGE (In years last birthday) 81 yn. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY Engineering | |
| 11. BIRTHPLACE (State or foreign country) Illinoise | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM D. STROUP | | 14. MOTHER'S MAIDEN NAME MARY WILSON STREEPY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. One | | 16. SOCIAL SECURITY NO 515-09-1956 | |
| 17. INFORMANT Mrs. Sarah C. Stroup, | | Address 95, Stewart Manor Frederick, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Volvulus of large bowel DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH 48 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive HEART DISEASE | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12/15 , 19 60 , to 12/17 , 19 60 , that I last saw the deceased alive on 12/16 , 19 60 , and that death occurred at 2⁰⁰ A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Richard C. Reynolds, M.D. 9 E. Church St. Fredrick, Md. 12/17/60 | | | |
| ACTUAL SIGNATURE Richard C. Reynolds | | PHYSICIAN'S NAME (Type) RICHARD C. REYNOLDS M.D. 9 E. Church St. Fredrick, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 12/20/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY | | 22d. LOCATION (City, town, or county) (State) Ft. Myer Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE DAILEY'S FUNERAL HOME | | ADDRESS FREDERICK, Md. | |
| 24a. REC'D BY REGISTRAR DEC 21 '60 | | 24b. REGISTRAR'S SIGNATURE C. S. S. Hines | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



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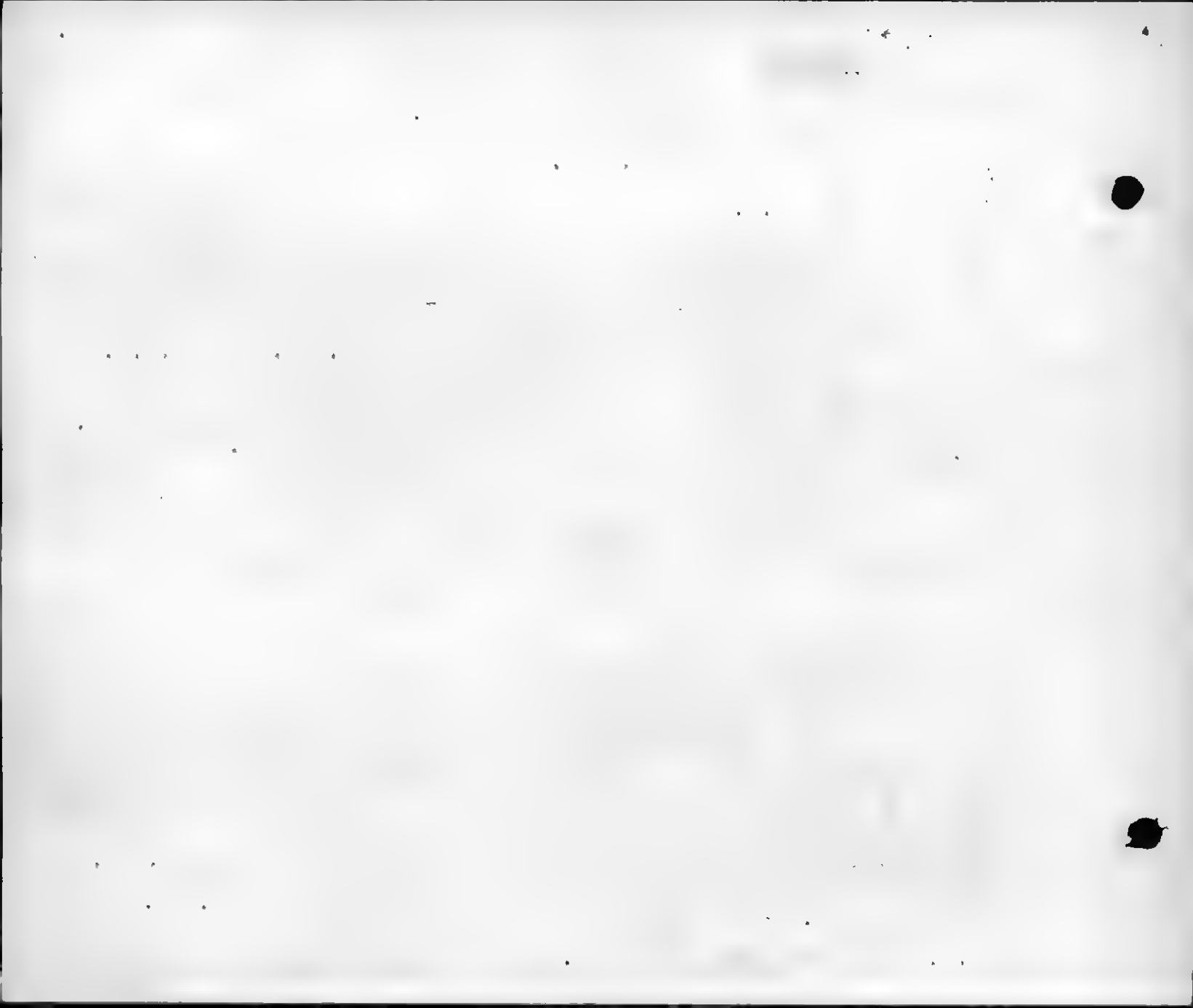


CERTIFICATE OF DEATH

Reg. Dist. No. 13873

13900

| | | | | | | | |
|--|------------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural | | | | c. LENGTH OF STAY IN 1b 1 yr. 3 Mon. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ijamsville P.O. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Ossie Middle Thompson Last Thompson | | | | 4. DATE OF DEATH Month December Day 31 Year 19 60 | | | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 21-1937 | 9. AGE (In years last birthday) 73 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY ***** | | 11. BIRTHPLACE (State or foreign country) Frederick Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Young | | | | 14. MOTHER'S MAIDEN NAME Nannie Hawkins | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 215-20-2120 | | INFORMANT Frederick-Md. Roland Thompson-120 N. All Saints | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic heart Disease DUE TO (c) 20 yrs | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 20 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July , 19 59 , to Dec. 21 , 19 60 , that I last saw the deceased alive on Dec. 27 , 19 60 , and that death occurred at 5 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Rafel L. Under M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) R.L. MICHELS | | | | Shopping Center Frederick, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 4-61 | | 22c. NAME OF CEMETERY OR CREMATORY Ebernoezer | | 22d. LOCATION (City, town, or county) (State) Frederick Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks 111 Frederick, Md. | | | | 24a. REC'D BY REGISTRAR DATE JAN 6 '61 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Harris | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the 4th note, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMD-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13874

| | | | |
|---|------------------------|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont R.F.D.I | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont R.F.D.I | |
| c. LENGTH OF STAY IN 1b I 1/2 years | | d. STREET ADDRESS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mildred Mae Toms | | 4. DATE OF DEATH December 19 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec, 15, 1924 |
| 9. AGE (In years last birthday) 36 yrs. | | 10. IF UNDER 1 YEAR Months Days | |
| 11. BIRTHPLACE (State or foreign country) Frederick County | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Samuel Kinney | | 14. MOTHER'S MAIDEN NAME Belva Baugher | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT Wilber Toms, Thurmont R.F.D.I | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 416.0 Third degree burnes DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) slotting the underlying cause lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 1 minutes | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Clothes and bedding caught fire | |
| 20c. TIME OF INJURY Month, Day, Year 5 12/19/60 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) Thurmont R.D.I, Frederick (County) Md. (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE B.O. Thomas | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) B.O. Thomas, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | December 20, 1960 | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12/24/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Bethel | | 22d. LOCATION (City, town, or county) (State) Frederick | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.C. Barton, Wackerlyville, Md. | | 24a. REC'D BY REGISTRAR DATE DEC 23 '60 | |
| 24b. REGISTRAR'S SIGNATURE | | 24c. REGISTRAR'S SIGNATURE | |



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

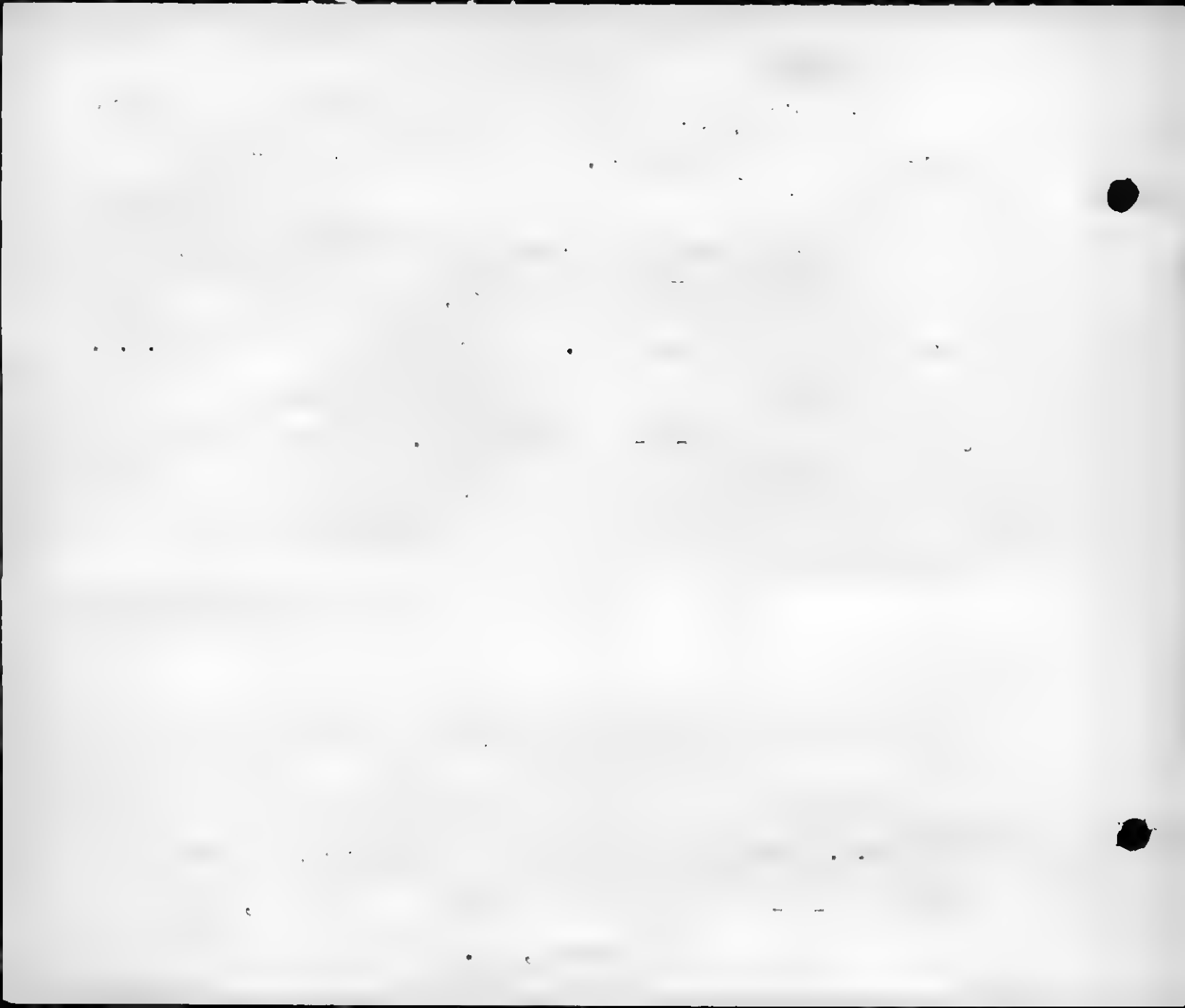
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13875

13902

CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg rural | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg rural | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home | | e. STREET ADDRESS 1 | |
| 3. NAME OF DECEASED (Type or print) First Kenneth Middle Robert Last Wagaman | | 4. DATE OF DEATH Month December Day 14 Year 19 60 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 30, 1914 |
| 9. AGE (In years last birthday) 46 yrs. | | 10. IF UNDER 1 YEAR Months 14 Days 19 Hours 60 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitarian | | 10b. KIND OF BUSINESS OR INDUSTRY Health Dept. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Howard Wagaman | | 14. MOTHER'S MAIDEN NAME Ruth Harbaugh | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 202-07-4917 | |
| 17. INFORMANT Carolyn B. Wagaman | | Address Emmitsburg RD 1 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic C.V. disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastric ulcer | | INTERVAL BETWEEN ONSET AND DEATH 1 hour | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 1, 1960 to Dec 14, 1960 , that (I) (we) last saw the deceased alive on Dec 14, 1960 , and that death occurred at 3 PM M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE W.R. Cadle | | 22b. DATE SIGNED DEC 20 '60 | |
| 22c. PHYSICIAN'S NAME (Type) W.R. Cadle | | 22d. ADDRESS Emmitsburg, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-17-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery | | 23d. LOCATION (City, town, or county) (State) Thurmont, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager | | 25a. REC'D BY REGISTRAR DEC 20 '60 | |
| ADDRESS Thurmont, Md. | | 25b. REGISTRAR'S SIGNATURE Robert L. Finner | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13877 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

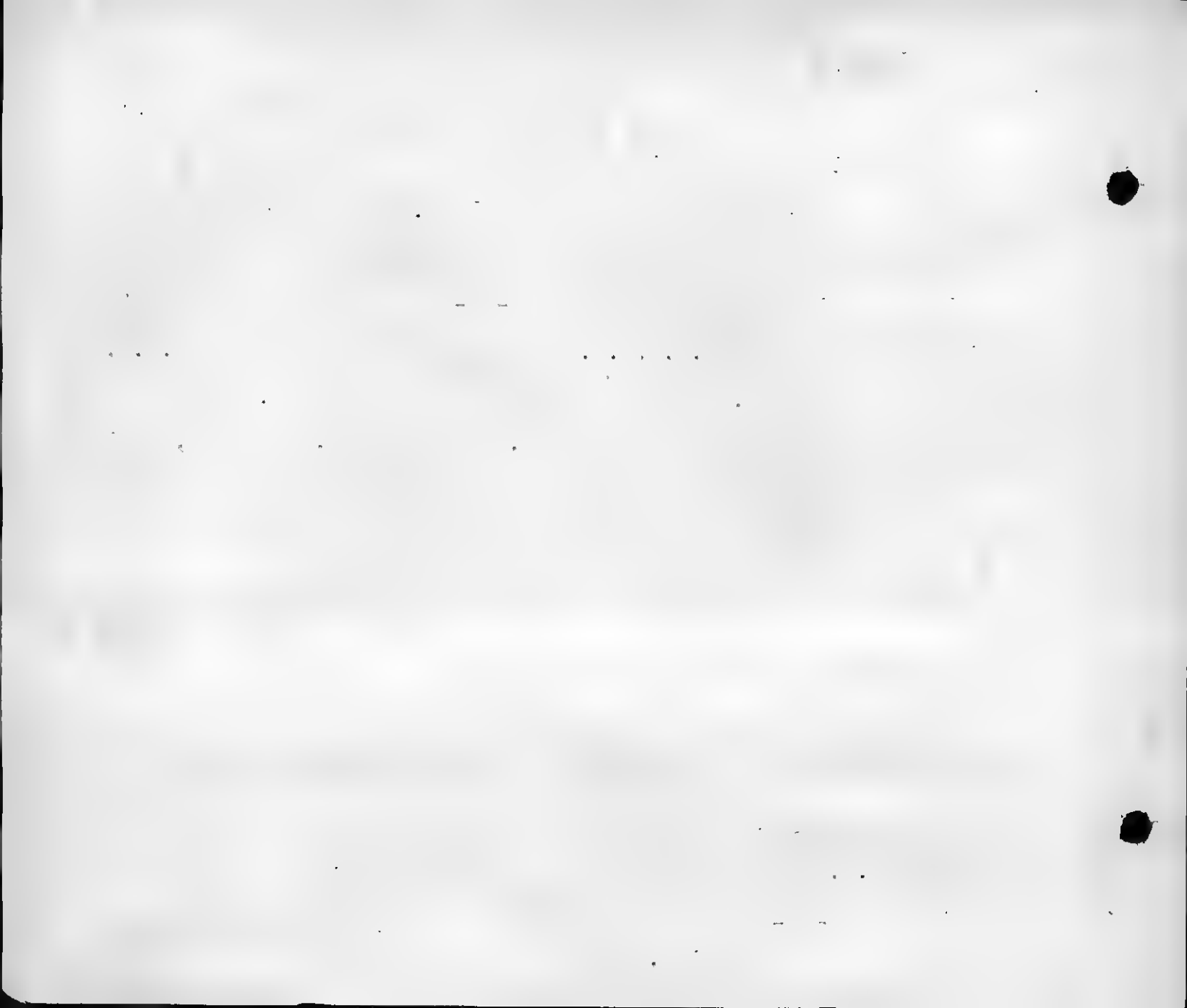
13876

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File #100-1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write R.U.R.A. and give nearest town) Brunswick | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maryland Avenue | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick | |
| 3. NAME OF DECEASED (Type or print) John Thomas Watts | | d. STREET ADDRESS 311 N. Maple Avenue | |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-15-1880 | |
| 9. AGE (In years last birthday) 80 yrs | | 10. IF UNDER 1 YEAR 12 Months 16 Days 1960 Year | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ENGINEER | | 12. KIND OF BUSINESS OR INDUSTRY B. & O. R. R. Co | |
| 13. BIRTHPLACE (State or foreign country) Maryland | | 14. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. FATHER'S NAME George T. Watts | | 16. MOTHER'S MAIDEN NAME Mary E. Keller | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 18. SOCIAL SECURITY NO | |
| 19. INFORMANT Mrs. Minnie Cooper, Knoxville, Maryland | | Address | |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion | | | |
| 420-1 DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE B. O. Thomas M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) B. O. Thomas | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 12-20-1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY Boonesboro | | 22d. LOCATION (City, town, or county) (State) Boonesboro, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. H. Felt ADDRESS Brunswick, Maryland | | 24. REC'D BY REGISTRAR DEC 23 '60 24b. REGISTRAR'S SIGNATURE C. L. F. R. M. | |



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MAY 6 11 27 12-27-60 et
MAY 6 11 27 12-27-60 et

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN lb 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown d. STREET ADDRESS 1 | |
| 3. NAME OF DECEASED (Type or print) Miss Nora M. Wise First Middle Last 4. DATE OF DEATH Dec. 13 1960 Month Day Year | | 5. SEX female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9/4/1889 9. AGE (In years last birthday) 71 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) accountant, ret. 10b. KIND OF BUSINESS OR INDUSTRY power company 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Charles Wise 14. MOTHER'S MAIDEN NAME Amanda Derr | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 214-10-2608 17. INFORMANT Mrs. Anna McBride, Middletown, Md. Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vase morrhage 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-vascular Disease DUE TO (c) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Had fall resulting in Colles Fracture, Lt. arm | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fall in Church | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 12/11 1960 Hour o. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Church 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 12/12 1960 to 12/13 1960 that (I) (we) last saw the deceased alive on 12/13 1960 , and that death occurred at 6:05 P.M. from the causes and on the date stated above. | |
| 22a. SIGNATURE A. A. Pearre 22c. PHYSICIAN'S NAME (Type) Dr. A. A. Pearre | | 22b. ADDRESS Frederick Md M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. DATE 12/14/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial 23b. DATE THEREOF 12/16/1960 23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery 23d. LOCATION (City, town, or county) (State) Middletown, Md. | | 24. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md. ADDRESS Gladhill Company, Middletown, Md. 25a. REC'D BY REGISTRAR DEC 19 '60 25b. REGISTRAR'S SIGNATURE Arthur S. Kenna | |

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STATE OF OHIO

1881



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13878

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| 1. PLACE OF DEATH o. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown | c. LENGTH OF STAY IN 1b 2½ years | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harmony Grove | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Valley View Nursing Home | | d. STREET ADDRESS Rural Frederick | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Zoe Middle E. Last Witter | | 4. DATE OF DEATH Month December Day 21 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 28, 1881 |
| 9. AGE (In years lost birthday) 79 yrs. | | IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. | IF UNDER 24 HRS. Months 79 Days 79 Hours 79 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Frederick County, Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Marshall O. Ramsbury | |
| 14. MOTHER'S MAIDEN NAME Mary Ellen Ogle | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. 215-14-2927D | | 17. INFORMANT Mrs. Edgar Hawker R.F.D. # 4 Frederick, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Essential hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential hypertension DUE TO Essential hypertension (c) Essential hypertension | | INTERVAL BETWEEN ONSET AND DEATH Days Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from August 14, 1960 to 12/21 19 60 ; that (I) (we) lost saw the deceased alive on 14 December 1960 , and that death occurred at 12/21 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE James B. Thomas | | 22b. DATE SIGNED 12-22-1960 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. James Thomas MD. | | 22d. ADDRESS 228 N. Market St. Frederick, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-24-1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State) Frederick, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dillhoff | | 25a. REC'D BY REGISTRAR Frederick, Maryland | |
| 25b. REGISTRAR'S SIGNATURE Clarence L. Harris | | DATE DEC 27 '60 | |

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